VARIABLES AFFECTING THE PERCEIVED JUSTIFIABILITY OF SUICIDE

by

MICHAEL STEINBERG

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By

Michael Steinberg

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The present study investigated the effects of several variables on freshmen and sophomore college students' perceptions of the acceptability of suicide. These include whether the suicide was precipitated by physical or psychological events, whether the protagonist was responsible or not responsible for bringing about the suicidal crisis, and whether the subject was male or female. In addition, all subjects completed the Threat Index, an instrument which measures the extent one is threatened by one's own death. This score was correlated with the acceptability ratings of the suicides. Respondents then read four case histories involving 40-44 year old male protagonists who had committed suicide. After each history, subjects rated the suicide on ten bipolar dimensions, on a scale of one to six. These dimensions include not justified/justified, cowardly/brave, unnecessary/necessary, insane/sane, and six others. The ten scores were summed, and higher numbers indicated greater acceptability for the suicide.

Of the four cases presented to each subject, two had physical precipitants which led to the suicide, and two had psychological precipitants. The physical cases concerned an individual who would be confined to a wheelchair for the rest of his life, and one who was afflicted with cancer. The psychological situations consisted of a male whose wife abandoned him, and one whose wife died after a car accident. Suicides also varied on a responsibility dimension. Certain protagonists were described as responsible in bringing about the events which ultimately contributed to their suicides. Others were depicted as having no control over these circumstances. Each subject received a physical-responsible, a physical-not responsible, a psychological-responsible, and a psychological-not responsible case.

Suicides involving physical precipitants were deemed more acceptable than those involving psychological ones. Also, the responsibility attributable to each protagonist was not a factor in determining how acceptable the suicide was. Rather, students seemed to be more attuned to idiosyncratic factors in each case. Furthermore, students with a higher death threat score were more likely to regard a particular suicide as acceptable. Males, overall, regarded suicide as more acceptable than females.

Implications of these results and limitations of the study are discussed.

CHAPTER I

INTRODUCTION

The history of suicide reflects the history of mankind (Wekstein, 1979). Suicide has been practiced for thousands of years in primitive and historic societies, but the ubiquity of the phenomenon has been associated with a wide diversity of attitude and feeling in the judgement of suicidal behavior. Societal reactions to the act of self-destruction can be viewed as a spectrum ranging from outright condemnation on the one hand, through mild disapproval, to acceptance and incorporation into the sociocultural system on the other (Rosen, 1968). Just as societies vary in their reactions to suicide, so attitudes within a society have changed in the course of time (Douglas, 1967).

History provides perspective for contemporary views of suicide. An historical approach makes it possible to see suicide in different temporal contexts, and to try to understand the meaning it has for people of varying backgrounds and experiences. At the same time, the relation of changing social conditions, value systems, institutions, and ideologies to the occurrence of suicide may suggest ways of viewing the present problem. It also may establish the circumstances under which individuals accept or reject human self-destruction (Fedden, 1980). Delineating some of these circumstances is the object of this research.

Suicide Among the Jews of Antiquity

There are only five descriptions of suicide in the Bible (only one is mentioned in the New Testament), and this paucity of suicidal instances has been the topic of much speculation (Wekstein, 1979). It is conceivable that such occurrences were cited only when they were deemed signficant, or that some suicides may have been perceived as accidents or natural deaths (Rosen, 1968). The infrequency of suicide among the Jews of the Old Testament period has also been attributed to an emphasis on life and a positive attitude toward the world. The Bible taught that the world was created by an omniscient God, and therefore the world was good. There is no evidence of prohibition or condemnation of suicide in either the Hebrew Bible or in the New Testament, and there were no desecrations of the bodies of those who did destroy themselves or punishments against their survivors (Westermark, 1906).

Suicide Among Greeks, Romans, and Their Neighbors

Attitudes toward suicide among the Greeks and Romans varied widely. Suicide to maintain one's honor was approved. These honor suicides to avoid capture, humiliation, and death are frequent in the conflicts among the Greeks, the Romans, and their neighbors. Moore (1952) reported that Augustus, the chieftain of the Sutani, a Celtic tribe, had a bodyguard of 600 picked men who were bound by a vow to live and to die with him, no matter whether the chief died in battle or of disease, or in any other manner.

Another form of suicide was the practice whereby a widow or a concubine offered her life when the husband or master died. Moore described this custom among the Thracians, who practiced polygamy. When a man died, his wives vied for the honor of being judged the one he had loved the most. The wife who was accorded this honor slew herself over the grave and was buried with her husband.

Early Christianity and Philosophy

Voluntary martyrdom was common among the early Christians. Many were filled with contempt for the human condition and felt themselves to be aliens in this world. In numerous individuals, this resentment was intimately associated with hostility toward the self, which often took the form of self-mutilation or suicide. Many were attracted to Christianity because it offered a chance of martyrdom and a possible opportunity to die as a blood-witness to Christ. Generally, Christians despised the tendency toward suicide among pagans; martyrdom, however, was considered a special case (Rosen, 1967).

What many downtrodden people looked for then was a meaning in life. A religion such as Christianity was the solution for some. Others espoused moral philosophies that offered a life with a scheme. The Cynic doctrine advocated a life of detachment and freedom, teaching men that conventional standards were worthless and urging them to extricate themselves from the bonds of social life. Epicureanism imbued its ideal of the calm life with a strong and driving quality of joy. Stoicism, the value of

actively doing good and taming the passions, provided a way of life for others (Rosen, 1967). The Cynics and Stoics accepted and even recommended suicide, but only under certain conditions, as an escape from evil. Epicurus, on the other hand, opposed suicide.

Suicide and Society in the Middle Ages

Unified antagonism to suicide began during the Roman Empire, and had several sources. One was economic, as the Christian Church continued Roman legislation against suicide by slaves. Moreover, as Christianity spread, it found itself opposing other religions and philosophies that condoned and even encouraged suicide. As a result, the Church declared suicide tantamount to murder. This position grew stronger with the increasingly important position of Christianity, first as a tolerated faith and then as the state religion. Under these circumstances, voluntary martyrdom was discouraged by Church leaders, and opposition to suicide was hardened (Fedden, 1980).

The views of melancholy as a vice leading to the sin of suicide by either promptings of the devil, or as a mental and emotional disorder due to a humoral excess and imbalance, explain in large part the varying social attitudes and practices with respect to suicide during the middle ages. In the thirteenth century, an ordinary suicide forfeited his goods, while one who killed himself to avoid a felony conviction forfeited both goods and land. Suicide by the insane, however, was exempted from any criminal repercussions (Walker and McCabe, 1968).

Three penalties--confiscation of property, degradation of the corpse, and refusal of burial in consecrated grounds--reflect prevailing attitudes toward suicide from the late fourteenth through the eighteenth century. The extent to which these penalties were issued varied from time to time and place to place. Generally, penalties against the body of a suicide tended to lapse by the latter part of the seventeenth century, and the sanction of confiscation was also handled more leniently. Important considerations were the social rank of the suicide and his family, as well as the circumstances of the suicidal act (Crocker, 1952).

Some causes of suicide were considered more justified than others. Self-destruction because of extreme physical illness, mental and emotional disorder, or similar conditions did not subject the suicide to any penalties in Prussia in the early eighteenth century. On the other hand, poverty, indebtedness, dishonor, or despair were not regarded as a sufficient justification of suicide. This differentiation tends to reflect new attitudes toward suicide which began to emerge tentatively during the Renaissance and finally came out into the open in the eighteenth century (Rosen, 1968).

The Effect of the Environment

Suicide was regarded as so widely prevalent in England by the middle of the eighteenth century that many believed the problem was so grave as to be considered a national emergency. Whatever the case may have been, there is no doubt that by the early nineteenth

century suicide was being considered less in moral and theological terms and more as a social and medical problem (Rosen, 1975).

The question "Is suicide on the rise?", which had already been raised in the eighteenth century, became even more prominent as reliable data on suicide began to be collected in the nineteenth century. This question was considered important because this was also the period of the early Industrial Revolution, with its attendant signals of social maladjustment. The purported increase in the incidence of suicide was perceived as another consequence of this situation. Furthermore, by linking suicide with mental disorder, the issue was brought into the larger realm of the relationship between civilization and madness, and the role of social stresses in the etiology of such conditions. Physicians, statisticians, and social reformers attempted to investigate the causes of the alleged increase in self-destruction. These seminal projects occurred mostly in France, given the French superiority in public health and social theory during the first half of the nineteenth century (Rosen, 1963).

The ideas that suicide was an urban phenomenon, occurring in large cities, especially Paris, and that suicide was related to poverty and thus occurred more frequently among the laboring poor, were repeated by numerous writers in the 1840s and 1850s. On the whole, these projects can be characterized by an increasing utilization of statistical knowledge, an effort to explore suicide as a social phenomenon, and a trend to relate these aspects wherever possible with data derived from anatomy and clinical

observation. These patterns could be discerned not only in France, but Great Britain, Central Europe, and the United States (Crocker, 1952).

Efforts were made to relate the kinds, occurrence, and distribution of suicide to such factors as climate, urban-rural residence, age, sex, marital status, socioeconomic class, occupation, and disease. These investigations had certain flaws; the population samples with which they dealt were too small or not representative, and often the populations at risk were either not known or not indicated (Perlin, 1975).

In addition to this statistical-sociological perspective, a medical-psychiatric approach attempted to explore further the phenomenon of suicide. Leopold Auerbrugger, in 1783, published a slim volume on suicide as a disease in and of itself. Spurzheim characterized suicide as a form of insanity produced by a disease of the body which revealed itself in chronic cases by thickening of the skull (Rosen, 1975). Brierre de Boismont, probably the most important contributor to the problem of suicide in the 1850s, listed insanity, alcoholism, illness, family troubles, love problems, and poverty as the most important causes of suicide. More generally, he saw suicide as a consequence of changes in society leading to social disorganization and to alienation for many people. This emphasis was strengthened by Boismont's conversations with 265 individuals who either had planned or attempted to commit suicide (Rosen, 1963). Systematic inquiry into the phenomenon of suicide began to replace a previous focus of

approval or condemnation of the act based on moral, philosophical, or personal orientations.

Sigmund Freud and Emile Durkheim

It can be seen that for centuries, speculation and superstition about suicide were largely intermingled with moral, religious, and philosophical dogma. In the beginning of the twentieth century, when scientific methodology was well on its way, Freud and Durkheim dispersed many archaic notions and opened more objective avenues for the exploration and study of suicide (Gibbs, 1968), building on the findings of their predecessors. It is with these two figures that the contemporary approach to the study of suicide began (Friedman, 1967).

At a 1910 symposium, Freud was brief and cautious (Friedman, 1967, p. 37):

> I have an impression that, in spite of all the valuable material that has been brought before us in this discussion, we have not reached a decision on the problem that interests us. We were anxious above all to know how it becomes possible for the extraordinarily powerful life instinct to be overcome; whether this can only come about with the help of a disappointed libido or whether the ego can renounce its self-preservation for its own egotistic motives. It may be that we have failed to answer this psychological question because we have no adequate means of approaching it. We can, I think, only take as our starting point the condition of melancholia, which is so familiar to us clinically, and a comparison between it and the affect of mourning. The affective processes in melancholia, however, and the vicissitudes undergone by the libido in that condition, are totally unknown to us. Nor have we arrived at a psychoanalytic understanding of the chronic affect of mourning. Let us suspend our judgement till experience has solved this problem.

Approximately ten years prior to Freud's statement, Emile Durkheim (1897/1952) first argued that society is qualitatively different from individuals. By interacting or associating with one another, social facts result which transcend any single contribution. For Durkheim, the suicide rate as a collective representation could not be explained by the motivations of any single suicide. The whole (the suicide rate) is greater or different in kind from its parts (individual suicides).

Durkheim examined the influence of psychological factors upon the suicide rates of social groups and found them to lack predictive power. Therefore, by elimination, he felt that social variables must be used (Lester, 1972). Durkheim also noted that suicide rates were stable within populations and varied widely between populations, which suggested to him that suicide rates form stable and reliable variables that would be amenable to study.

Durkheim's Theory

Four etiological types of suicidal behavior are included in Durkheim's conceptualization. These four types form two groups. The first group, which is comprised of egoistic suicide and altruistic suicide, is rooted in the concept of integration of the societal group. A society is integrated to the extent that its members possess shared beliefs and sentiments, interest in one another, and a common sense of devotion to common goals (Johnson, 1965).

Suicidal behavior is common in societies where there is a high degree of social integration (altruistic suicide) and in

societies where there is a low degree of social integration (egoistic suicide). Societies with a moderate degree of social integration have the lowest incidence of suicide. Egoism is the product of excessive individualism, and the individual is protected from egoism by religions with strong group ties, family ties (particularly where children are involved), or political affiliations. When the ties in a society are minimal, Durkheim claimed, then suicide becomes more likely. At the other extreme the individual can be too closely integrated and identified with a particular group. He may take his life, for instance, as a religious sacrifice or as a result of political allegiances.

The second social variable that Durkheim proposed was social regulation. A society is regulated insofar as the society has control over the emotions and motivations of the individuals in it. Suicidal behavior is common in societies with a high degree of social regulation (fatalistic suicide) and in societies with a low degree of social regulation (anomic suicide). Societies with a moderate degree of social regulation have the lowest incidence of suicidal behavior. Subsequent testing of Durkheim's hypotheses in different settings have largely supported his conclusions (Maris, 1969).

Contemporary Suicide Research

The majority of contemporary investigators have focused their efforts on the suicidal person himself (Lester, 1972). Many have examined the possibility of a predisposition to suicide,

including the inheritance of suicidal inclinations (Kallman, 1953; Shapiro, 1935), constitutional factors in suicidal behavior (Green, 1967; Jones, 1965; Sheldon, 1942), sexual and cultural differences in suicidal behavior (Davis, 1968; Noroll, 1962), and the relationship between childhood experiences and suicidal tendencies (Bell, 1968).

Another prominent line of research has concentrated on the suicidal person in the context of his environment. Temporal factors in suicidal behavior (Blackly and Fairley, 1969; Edwards and Whitlock, 1968), the social relationships of the suicidal individual (Breed, 1966; Sifneos, 1966; Vinoda, 1966), and the relationship between suicide, suggestibility, and contagion (Motto, 1967; Seiden, 1968), have all received considerable attention.

The two areas of major research interest appear to be the suicidal personality and the psychotherapy of the individual contemplating self-destruction. Personality studies have examined the thought processes of the suicidal individual (Neuringer, 1961), suicide as an act of aggression (Litman, 1967), personality correlates of suicidal inclinations (Dorbonne, 1969; Hendin, 1963; Otto, 1964), and mental disorder and suicide (Gittleson, 1966). The most renowned theorists and mental health practitioners have also offered their contributions, and the literature is replete with such figures as Adler (1967), Fenichel (1945), Horney (1950), Jung (1959), Maris (1970), Schneidman (1967), and Sullivan (1956).

Theoretical Issues in Attitudes Toward Suicide

While the vast majority of the research described has been empirical, most of the literature concerning whether suicide is a justifiable act has been theoretical. A discussion of these theoretical issues will follow.

Pandey (1971) proposes that our understanding of death and control over it have suddenly expanded to such a degree that the religious and philosophical foundations of our classical systems of human values, as well as many time-honored concepts, have become antiquated. Kalish (1965) suggests that the following four guidelines should be taken into account in value decisions about the control of death. His guidelines reflect value definitions, which he accepts and which he would like to have adopted by society at large.

The first consideration holds that a man's life belongs to him--not the state, church, family, medical profession, mental health movement, or economic system. A man's death also belongs to him and not to other agencies, institutions, or individuals. Thus, decisions about the life and death of an individual should not be made without involving the one affected in the decision-making process. Secondly, the maximum preservation of biological life need not be an overriding value. Next, Kalish maintains that dignity, physical comfort, and human relationships are just as important for the person with a few hours left to live as for an individual with a life expectancy of 50 years. The final guide-line asserts that individual differences occur throughout the

lifespan, and obviously extend throughout the dying process and after.

Related to the control of death is the evaluation made concerning specific types of deaths. Sudnow (1967) claims that one group of factors that may influence evaluations of suicides is the background and demographic profile of the suicidal individual. For example, the typical reaction to an elderly man's suicide is not likely to be as disapproving as that toward the suicide of a young pregnant woman. Such a discrimination may reflect a philosophy that the old man was more justified in his act than the woman was. On another level, a greater value may be placed on the life of the woman, or the woman's death may be seen as less appropriate.

Sudnow (1967) observed that this tendency to make value judgements about the importance of other people's lives (or the appropriateness of their deaths), may occur naturally in an environment where death, particularly that of undistinguished individuals, is a common and anticipated occurrence such as in a large hospital. In such a setting, only an atypical death, such as one involving a child or suicidal individual, is likely to disrupt institutional procedures and elicit emotional reactions from staff members.

Theoretical Arguments for the Acceptance of Suicide

Haverwas (1981) and Wallace and Eser (1981) believe that it is rationally justified to kill oneself when a reasonable appraisal of the situation reveals that one is really better off dead. In

judging whether a person would be better off dead, these authors take into account not only the person's present and future values, but also his personal ideals and personal integrity.

Motto (1972) argues that the individual undeniably has the right to kill himself. He does question, however, the extent to which the exercise of that right should be subject to limitations. Motto (1983) proposes that the intensity of pain, one's threshold of pain tolerance, likelihood of relief, capacity for rational thought and autonomous activity, religious meaning of death, the value system of the individual, potential impact on others, and the potential for meaningful relationships should all be considered when justifying an individual's decision to end his life.

Szasz (1971) contends that the individual is essentially always justified when he decides to put an end to his life. For Szasz, this is the ultimate expression of one's freedom and humanity.

Theoretical Arguments Opposing Suicide

Elizabeth Kubler-Ross (1974) maintains that there is no living condition or situation from which some meaning and fulfillment cannot be extracted. As an extension of this belief, she proposes that suicide can never be rational or justified.

In discussing suicidal impulses of clients, Burton (1972), Hendin (1981), and Litman (1965) point out that therapists need to avoid becoming unduly frightened by the possibility that a client will commit suicide. When suicide is explored in therapy,

it is an indication that clients are being reached and that they need to be reached on a deeper level. The contemplation of suicide can be interpreted as a way of refusing to live in old ways, and the therapist's task is to give protection and support as the client searches for new reasons to live. These authors also argue that a suicide attempt may be an endeavor to improve one's relationship with others.

Olin (1978) offered the hypothesis that the pre-suicidal patient may suffer from an impairment of reality testing in which suicide is not thought of as lethal; suicide then becomes dying without death. The emotional crisis present in the pre-suicidal state, plus the possible effects of sleep deprivation and drugs, can lead to ego regression in which primary process thinking can influence the person's concept of suicide. As an illustration, injuries are not realistically considered, and death is somehow perceived as reversible.

Kiev (1975) argues that suicide, if considered at all, is usually viewed as a way out or as an end to suffering, rather than as a clear decision to die. Shneidman (1974) introduced the concept of "tunnel vision" endemic to the psychological predisposition to suicide. When an individual gets into a suicidal frame of mind, his objectivity diminishes; the scope of his world narrows and excludes positive feelings. Neuringer (1979) supports the view that suicidal people are characterized by cognitive rigidity, expressed in the inability to find and use new solutions in a crisis. Shneidman and Neuringer both agree that in most instances,

the potential suicide's estimate of his situation is probably faulty and quite amenable to correction.

Schneidman (1974) adds that due to man's difficulty in imagining his own death (and probably the deep-seated belief in immortality), one expects to be alive and present even after one is dead. Thus, like Olin (1978), Shneidman believes that suicidal people do not regard killing themselves as final.

Brandt (1975) asks whether suicide intervention is justified on the grounds that the would-be suicide himself might have decided differently at a later time. A rational man chooses his best alternative, and that is precisely what most depressed, hopeless, alcoholic, lonely (in short, pre-suicidal) people cannot do.

Siegel (1982) maintains that suicide is a highly ambivalent act, undertaken by individuals who, while seemingly intent on dying, never give up the hope of living. She argues that an objective, rational view of life is rarely present in the suicidal individual. Rather, a sense of controlling exactly how and when they will die appeals to the omnipotent strivings of some suicidal people. An unwillingness to accept life on any terms but their own characterizes others. Still others attempt to give their life more meaning by attaching their suicide to a larger cause (social or political).

Siegel (1982) does not maintain that rational suicide does not exist--she believes it does. The preponderance of available evidence, however, strongly suggests to her that such cases are

sufficiently rare as to be negligible from a point of view of social, psychological, and medical prevention. Thus, Siegel feels justified in seriously challenging most suicidal patients' decisions.

The Current Study

Kalish, Reynolds, and Farberow (1974), along with Calhoun, Selby, and Gribble (1979), argue that more empirical research is needed to determine what factors, if any, affect people's attitudes about whether or not a particular suicide is a justifiable act. Vernon (1972) speculated that a given suicide is typically interpreted in terms of the situational factors involved. He further postulated that most specific suicides today are not condemned, and wondered if the maximum preservation of a particular life in a particular situation seemed to be increasingly subject to elements of doubt. It is these questions to which the current research addresses itself.

Variables which might determine the perceived acceptability of a completed suicide were investigated. It was assumed that under some conditions, suicide would be construed as an alternative to life. While previous researchers have not conducted detailed examinations of people's attitudes toward suicide under extraordinary circumstances, their general conclusions support the perspective that some tolerance for suicide exists (Kaplan, 1974; Shneidman, 1971; Singh, 1979; Wallace, 1973). This acceptance occurs most typically in instances where the individual

is depicted as suffering unbearable pain from a fatal or chronic illness, perhaps because it is believed that the resultant pain and suffering can render life unendurable and suicide justifiable (Cappon, 1970; Staninger & Colsher, 1979).

Specifically, four sets of factors are relevant here. One set involves characteristics of the crisis or situation which precipitates the suicide. In the context of justifiability, the idea that college students would respond differently when the suicide involves a protagonist confronted with a severe physical precipitant than when subjected to intense psychological or mental stress, was tested.

Second, differential responding was examined for those completed suicides in which the protagonist actively created the conditions which ultimately contributed to the decision to take his life, as compared to those individuals whose personal misery was the consequence of conditions over which they had no control.

The third factor studied focused on the perceiver's conceptualization of personal death, relating these reactions to the aforementioned variables. Theoretically, one with a high level of death threat has been unable to integrate a significant aspect of human existence into his understanding of self. Regarding oneself as virtually immortal appears to be suggestive of a basic flaw in one's perception of human reality (Rigdon, Epting, Neimeyer, and Krieger, 1979). Empirically, it has been demonstrated that high death threat individuals (as determined by the Threat Index), reported being comparatively less able to conceive of their own mortality (Krieger, Epting, and Leitner, 1974).

The fourth factor examined whether the sex of the respondent related to the perceived justifiability of the suicide cases presented.

CHAPTER II

REVIEW OF THE LITERATURE

It can be seen that countless attempts to impose some organizational structure on suicide have been made. These range from theoretical discourses and classification schemes of suicide motives, to types of suicide-prone personalities, to the clinical management of the suicidal patient, to investigations of cultural views of both the act and the actor (Cutter, 1970; Durkheim, 1897/1952; Menninger, 1958). Out of these varying efforts at least two predominant lines of thought have emerged (Droogas, Siiter, and O'Connell, 1983).

First, it might be misleading to conceive of suicide as a unitary phenomenon. Suicide may best be regarded as developing from any one (or combination) of a multiplicity of underlying causes. Second, it does not seem to be clear that suicidal behavior is always impulsive, irrational, maladaptive, or unconsciously motivated--as it is usually defined within a psychoanalytic context (Jacobson, 1964). Hence, there are arguments for the idea that under certain circumstances, suicide may be considered an objectively justifiable act. Related to this, certain research has suggested that notions of the maximum preservation and worthwhileness of human existence are not universally upheld.

Swyter (1979) describes four case studies challenging the ideal value that life is preferable to death. The first case concerns a patient already on dialysis where both the physician and patient want to continue with the procedure. The patient and staff are coordinating their efforts to maintain the values of patient integrity and right to decide to support life and promote health, to work together as a team and, most importantly, that all believe that life is valuable and preferable to death.

The second case describes a variation; both the patient and physician came to a mutual decision to discontinue hemodialysis. Swyter comments that even though the staff feels the situation is hopeless and it is the physician who really decides to stop and the patient who concurs, there is still a general feeling that life is preferable to death, that the physician has posed the alternatives, that the patient has decided, and so comfort is given and dignity maintained. The author proposes that death is never explicitly defined as preferable--it is just allowed to happen.

The third case demonstrates an acute conflict situation; even though she is doing well on dialysis, the patient chooses to stop. Here, the ideal value that life is preferable to death is violated. The patient insists on the ideal values of her right to decide about stopping dialysis, on her right to a dignified death, and on her right to be treated as a normal, living individual. In doing this, Swyter argues that she is taking the decision-making away from the physician, demonstrates that dying is sometimes

preferable even with no other fatal disease, refuses to "fight to live," and totally collapses the normal routine.

The final case also represents a stressful conflict situation. A dialysis patient is viewed by hospital staff as dying of lung cancer. He is in pain but does not want to stop dialysis. The staff views stopping as the only "right thing to do." Thus, the patient's pain becomes a focal point for the push to terminate dialysis. The patient, however, does not view pain as a reason to commit what, to him, would be suicide. The staff decides to discontinue the treatment.

Swyter concludes that in the first two cases, the ideal value is maintained even though one patient dies. In the third situation, it is the patient who challenges the ideal as she believes she has lived her life and it is time for her to die. It is the last patient who causes a reversal of the ideal value because of his pain. He upholds the original ideal value, and it is the staff who says in this case, death is preferable to life.

These four case presentations demonstrate to the author the subtle but dramatic interplay between ideal and real value orientations. Of the many factors involved in their restructuring, he believes pain to be the most important.

Mansson (1972) discovered that for many people the establishment of personal justifications that sanction killing seems to be of greater importance than is the "evilness" or "goodness" of killing per se. His overall data demonstrate that the values

ordinarily associated with a commitment to, and a belief in, the sacredness or inherent virtue of human life are not unqualifiedly shared by everyone. Mansson asked the question whether people might be willing to make judgements of social worth for reasons much less noble than that of saving lives.

Mansson had 570 college students respond to one of four variations of a proposal that "unfit" persons be put to death (to mitigate the population explosion, put them out of their misery, and to stem the disproportionate increase of an undesirable segment of the population). In no condition was there less than 29% approval, and in five of eight conditions over 60% approved. The author concluded that, in general, justification articulated by the experimenter to put these people to death seemed to be justification enough.

Attitudes Toward Suicide

Schneidman's 1971 survey on death in a popular psychology publication tapped the responses of 70,000 individuals; 68% believed that there are circumstances in which a person should be allowed to take his own life; 90% admitted to occasions in their lives when they contemplated suicide; 76% revealed that if they were to take their own lives, the reasons that would most motivate them to do it would not be physical illness or pain. Finally, 92% of the sample either tended to or firmly believed that psychological factors can influence, or even cause, death. Results must be qualified in that the preponderance of the sample was female, urban, and professional.

In a study conducted by Klopfer and Price (1979), the majority of respondents tended to approve the concept of suicide in exceptional cases (although such cases were not described), to approve the concept of euthanasia, to prefer death by natural rather than accidental causes, and to believe in an afterlife. The authors reasoned that perhaps a belief that one has a better destination is an encouragement to die abruptly. Overwhelming support was also received for the idea that it is better to die at 70 and healthy than it is to die at 75 after five years of being bedridden and helpless.

Welu (1972), in his investigation of psychological reactions of emergency room staff, found that doctors verbally communicated less tolerance toward the individual who had attempted suicide than did nurses. Welu's analysis of the physicians' response patterns led to the suppositions that perhaps doctors are intimidated by the irreverence for life expressed by the suicidal gesture, and that physicians may resent those suicide attempters who use medicine in a destructive manner.

Singh (1979) states that patterns of approval and disapproval of euthanasia and suicide vary depending on the sociodemographic, socioeconomic, religious, and ideological characteristics of respondents included in previous studies. These investigations suggest to the author that older, more religious, less educated, and black respondents are likely to be opposed to euthanasia and suicide.

Singh (1979) also found that attitudes toward euthanasia and suicide may be influenced by such factors as one's commitment to

freedom of expression for others and their political views, since such attitudes involve decisions about freedom of choice. He concluded that those regions which were less urbanized were less likely to approve of euhanasia and suicide. Singh inferred that approval of suicide is part of one's general orientation toward freedom of expression, and those who approve of freedom of expression are likely to approve of choices made by those who will consider ending their lives either by themselves or by asking physicians to end their lives.

Gurrister and Kane (1978), in their discussion of how therapists preceive and treat suicidal patients, suggest that the suicidal person makes a great impact on his helper. Litman (1970) interviewed a number of psychiatrists who lost patients through suicide and found that reactions were profound, including persistent dreams, symptom formation, and identification with the dead patient. In none of these cases did the psychiatrist support the patient's decision.

Wallace (1973) and Kaplan (1974) found that actual experience with a suicide in a therapist's caseload seemed to render the therapist more protective of other patients, and more sensitive to the life threatening nature of various problems. It also seemed to make the therapist less judgemental; therapists who experienced a suicide were significantly less likely to brand the suicidal patient as one who projects blame on others and more likely to perceive him as deeply self-blaming.

Siegel (1982) revealed that approximately 95% of all suicides involve those individuals facing a nonphysiological trauma and whose situation, from an outsider's vantage point, does not appear hopeless or unbearable. Other investigators reveal that attempts outnumber completed suicides by more than 8:1, a failure rate that tends to support the notion that these individuals are not unequivocally resolved on dying (Albert, 1975; Beck and Morris, 1974; Kastenbaum and Costa, 1977; Schneidman, 1985).

Frederick (1971) indicates that the manner in which suicide is regarded depends on the person's personal and social orientation and on the nature of that individual's involvement with any given suicide. Forty mental health professionals and 40 non-professional, college-educated business people were asked to rank their attitudes toward eight popularly acknowledged undesirable behavioral events: lying, murder, cheating, suicide, robbery, adultery, marriage to another of different religion, and marriage to another of different race. Respondents were also asked how they would feel if a member of their own family committed suicide.

Ninety per cent of the non-professionals viewed murder and suicide as the two most undesirable behavioral events, and the same number of non-professionals expressed negative attitudes toward suicide within their own families. The mental health professionals, however, perceived only murder as the most undesirable behavioral event, and 65% of this group held positive attitudes toward accepting suicide. Nevertheless, when these same individuals

were asked about possible suicide within their own families, 80% reacted in a negative fashion.

Frederick concluded that as long as suicide can be held at a distance and removed from one's personal life, effective intellectual techniques can be used to deal with it. With college-educated persons, taboo attitudes against suicide are likely to be inadmissable among health professionals, but conscious and admissable among non-professional business people. Frederick further asserts that it is possible to think consciously that the suicide taboo ought to be broken and yet to retain strong unconscious beliefs and feelings that it should not.

Additional Research on Attitudes Toward Suicide

Ginsburg (1971) reports that suicidal behavior is considered shameful by most people; in fact, by more than consider mental illness shameful. Both the suicidal person and his family are likely to have a pall of stigma cast over them. This gives clear support to the widely held belief among health professionals that suicide is considered a shameful event and a taboo topic. Ginsburg's study also indicated that most people believe that a person who says he intends to commit suicide will not actually do so. Most people also believe that even those who die as a result of suicidal action did not really want to die. His sample perceived suicide as something that happens to someone, rather than something that one does for a reason. Fifty-six per cent of respondents expressed the view that people do not have the right to take their own lives.

An investigation by Cowgell (1972) demonstrated that subjects who heard a suicidal communication on tape showed greater vasoconstriction as the suicidal communication occurred, and had more feelings of tension and anxiety later than those who did not receive a suicidal communication. Even in the context of listening to someone who was depressed, desperate, and complaining, the presence of an explicit statement that suicide was intended was associated with significantly increased sympathetic arousal, and with a significantly more uncomfortable mood state. The study also found that friends and relatives of actual suicides reacted to suicidal threats by ignoring them and trying to continue the relationship as though they had not occurred. Reactions such as disbelief and denial were common in the general population.

Selby and Calhoun (1975) studied the causal explanations employed by naive observers for suicidal behavior, examining the impact of the following factors: sex of the respondent, whether the person was described as attempting or committing suicide, and the sex of the person engaging in the suicidal behavior. Each subject responded to a paragraph description on the following dimensions: degree of suicidal intentionality, degree to which the suicidal behavior was caused by personality characteristics, degree to which the individual was mentally ill, and the degree to which the episode was caused by environmental pressures.

The sex of the respondent did not have a reliable effect on any of the dependent variables. The sex of the suicidal person,

however, produced a significant difference in the degree of inferred intentionality. Suicidal females were seen as more intentional, and females engaging in suicidal behavior were also seen as more mentally ill than males. Finally, the suicidal behavior of attempters was seen as caused by personality traits and characteristics to a greater extent than the suicidal behavior of committers, and there was a tendency for persons described as attempting suicide to be seen as more mentally ill than those actually committing suicide.

Kalish, Reyolds, and Farberow (1974) concluded that college students are much less likely to describe suicidal persons as mentally ill and much more likely to feel that they are under extreme stress. The better educated are less likely to consider either bravery or cowardice as characteristic of suicide. The one category that increased in acceptability with higher educational level was that of asking for professional help and attention.

Calhoun, Pierce, Walters, and Dawes (1974) found in a sample of factory workers that individuals seeking help for problems caused by external factors (for example, job situation), were rejected less and were ascribed a lesser degree of mental illness than when their problem was caused by internal factors (for example, personality). Sale, Williams, Clark and Mills (1975) showed that respondents regarded suicide and attempted suicide as something that "happens" to people, rather than an intentional act. They also found that respondents with unfavorable attitudes tended to believe that suicide attempts hardly ever lead to death.

Domino, Moore, Westlake, and Gibson (1982) argued that although suicide occurs in a cultural context, community attitudes have not been explored fully. They presented a 100-item questionnaire to a sample quite heterogeneous in demographic composition, including graduate students in counseling psychology, housewives, firemen, secretarial staff, and visitors to a large shopping center.

The overall results suggest to the authors that attitudes toward suicide are a rather complex phenomenon that requires a more sophisticated approach than simply a positive or negative analysis. Factor analysis yielded 15 reliable and meaningful factors this sample considered when responding to the suicidal act. These factors accounted for 76.6% of the total variance.

The first factor indicates that, for this sample, suicide is an acceptable behavior in certain circumstances and that "potentially every one of us can be a suicide victim." Other items support the notion that individuals have the right to commit suicide and that suicide is not evil or shameful. Analysis of a second factor, however, expressed essentially the opposite view, namely that suicide is an evil, immoral act, and those who commit suicide are cowards, mentally ill, or trying to elicit sympathy. Domino et al. speculated that the label of mental and moral illness in these items illustrates the dual aspects involved in this factor.

Analysis of other factors produced a multitude of findings. While suicide is bad, it is not so serious and is possibly a

reflection of man's aggressive nature; once suicide is attempted, future attempts are unlikely, and suicide in young persons is puzzling, must be the result of a weak personality, and must be punished by separate burial. Other results include the notions that suicide is the result of lack of religious convictions or family ties; that obesity, parental suicide, and broken home are seen as aspects that contribute to a higher rate of suicide; that suicide attempts are the result of an impulse rather than premeditation; and that the suicide attempter is not lonely or depressed, does not seek help, appears normal to relatives, and perhaps appears normal even to himself.

Domino et al. believe that further refinements of the questionnaire are probably necessary, but these initial results support the usefulness of the instrument and the complexities of attitudes toward suicide.

Bell (1975) exposed an experimental group to an 18-week course on the social aspects of death, dying, and suicide. Pre and post-test measures of death attitudes were obtained. The data indicated significant changes in the cognitive-attitudinal component of those in the experimental group. These individuals entertained more frequent thoughts of death and suicide and manifested a greater amount of interest in death-related discussions than was true of the control group. Items constituting the affective dimension, however, were not appreciably altered by experimental procedures. Both groups indicated approximately

identical degrees of fear in relation to death and suicide, and expressed similar feelings toward discussing their own or a close friend's death with other persons.

Hart (1979) asks whether a culture can consider the question of suicide or euthanasia rationally as long as death remains a psychically unacceptable condition. Theoretically, an individual with a high degree of death-related anxiety ought to be more defensive and rigid in situations that force thought on life/death issues. Likewise, Hart argues, the more realistically and vividly a "death symbol" is portrayed to the high death-anxious person, the more one's psychological defenses would be threatened. One would predict that the high death-anxious person exposed to a highly personalized "death symbol" would tend to be less receptive to attitudinal change toward life/death issues in general, but particularly attitudes concerning suicide.

Four weeks after the administration of a death anxiety measure, Hart presented video and written case studies. His findings support the view that if the image of death and the issue associated with the image is dramatic and personalized, an individual appears less able to consider rationally the pros and cons of the issue. However, if the death issue is introduced in such a way that threats to ego defenses are less aroused, then an individual appears better able to weigh the problem intelligently. Hart contends that there will probably be less defensiveness from one for whom death is an acceptable part of life.

Since the current project investigated subjects' own death orientation and the way this correlated with reactions toward the suicidal person, an account of the procedures utilized to examine death attitudes will follow.

Studying Death Attitudes

In studying attitudes about death, problems of methodology are central (Durlak, 1972). Particularly in the context of projective data, overinterpretation is often the case (Simpson, 1980). Rodabough (1981), in his discussion of research strategies, distinguishes between observational methods and survey research. Observational procedures attempt to answer questions about human behavior and attitudes by watching what people do; survey methods ask people what their attitudes are or what they think they would do in certain situations. Large numbers of respondents can be questioned in such a manner that their responses are easily coded and submitted to statistical analysis by computer. These large numbers allow more adequate sampling, thus enhancing external validity.

A major problem exists, however, in the implicit assumption that respondents can verbalize their perspectives. This is not always the case, especially in an emotion-laden area in which open discussions have been largely prohibited. Moreover, the form and content of questions may shape the answer, and allowances must be made for the fact that many subjects will not have a well-formed, crystallized opinion, if any. In addition, subjects may try to

appear consistent in their answers, even when their true feelings or attitudes are inconsistent and contradictory.

Simpson (1980) levels these same deficiencies of direct self-report measures. Assuming that human beings are capable of verbalizing their attitudes about death, one is unsure whether people's responses to questions about their attitudes accurately reflect their true feelings. Surveying the results of many death-attitude measures, Simpson concludes that there is clearly insufficient evidence of their validity and reliability. Furthermore, considerations of social desirability surely influence responses to death-anxiety questionnaires.

Another indirect technique has measured latency periods and pauses in word association and tachistoscopic recognition tasks (Lester and Lester, 1970). Although longer latencies may be shown between death-related and neutral words, this may indicate a limited death-related vocabulary, as it is an area with far fewer developed response patterns.

The complexities inherent in assessing death attitudes is illustrated in Feifel and Branscomb's research (1973). Three levels of analysis were tested. On the conscious level, subjects were asked: "Are you afraid of your own death? Why?" Next, a fantasy level was employed to circumvent more formal intellectualized conceptions. Subjects were asked: "What ideas or pictures come to your mind when you think about your own death?" Answers were categorized as positive, ambivalent, or negative. Finally,

two techniques attempted to assess attitudes below the conscious level of awareness. First, subjects were presented with 20 nouns, 10 of which were death-related. All words were equally balanced on frequency/usage and syllable content. Mean differential reaction times, along with recall reaction times between death and neutral words were tabulated.

Next, a color-word-interference test was presented, whereby subjects were instructed to recall the color in which a word was written and to disregard its content. Theoretically, the evocative power of the content of the word is shown by its impeding effect on the reading of the color of the word. Again, words were equally balanced on color presentation, frequency/usage, and syllable content.

Feifel and Branscomb's results were complex. The dominant conscious response to fear of death was repudiation; that of the fantasy/imagery level was ambivalence; on the non-conscious level, outright negativity was the elicited reaction. The authors postulated that this apparent counterbalance of co-existing avoidance-acceptance of personal death most likely serves powerful adaptational needs, allowing one to maintain communal associations and yet organize resources to contend with inevitable death.

Even the older, more religiously inclined subjects, who manifested a capacity to perceive death in a fairly positive vein on conscious and fantasy levels, fell to seeming anxiety at the unconscious level. Most revealing was the common negation of fear

of personal death in subjects at the verbal level. Is it cowardly to admit death? Perhaps subjects were simply unwilling or unprepared to look at death candidly. Results may have indicated lack of communication with one's genuine feelings. Nevertheless, this investigation points to the importance of acknowledging the different levels of awareness in the context of death, and understanding which level is purportedly being tapped by a particular measure.

The personal construct approach offers a better chance of ascertaining the personal meaning of death for each subject, with less distortion by the experimenter's preconceptions and more sensitivity to the influence of each individual's personality structure (Simpson, 1980).

Kelly's Personal Construct Theory

George Kelly, the originator of personal construct theory, believed that the underlying goal of the individual is to predict and control experienced events. In this way, he conceived of people as scientists seeking to understand and forecast the events around them. These idiosyncratic perceptions, or personal constructs, serve not only as interpretations of past events, but also as hypotheses about events not yet experienced. Our current construing of events provides meaning to our past and direction to our future (Kelly, 1955).

Threat is experienced when a fundamental change is about to occur in one's construct system--when major beliefs about the

nature of one's personal and social world are invalidated. As an illustration, questioning the purpose of one's life is threatening, as it is likely to lead to basic conceptual change. Threat implies that an individual's hitherto well-ordered, meaningful world becomes transformed into one of confusion and disorganization. Kelly regarded death as the quintessential threatening event to most people.

The Threat Index

Research on death and dying in the context of personal construct theory was initiated with the development of the Threat Index (TI) by Krieger, Epting, and Leitner (1974). The TI evaluates death threat by assessing the individual's reluctance to conceptualize "self" and "death" on the same pole of a series of bipolar constructs. It is inferred that those who describe themselves and their deaths in similar ways are cognitively organizing their worlds in such a manner as to be capable of viewing death as a personal reality--as an occurrence compatible with their own lives. Conversely, those persons who posit themselves and death on opposite poles of the majority of their constructs would have to reconstruct their systems in a drastic way so that self and death could be construed together. The overall score on the TI is simply the total number of such splits on a given number of constructs (Neimeyer, Epting, and Krieger, 1984).

The original Threat Index takes the form of a particularly complex and detailed structured interview, intended to elicit

death-relevant constructs personally employed and generated by the individual, deriving "self" and "death" ratings on each of these dimensions. Only individual administration is possible, and the time required to complete the instrument ranges from 60 to 90 minutes. Its strengths include its potential to provide a clinically rich and personally meaningful depiction of the interviewee's construal of death, along with the capacity to stimulate psychotherapeutic exploration of a client's death concern. Despite its advantages, the elicited form of the TI requires a lengthy interview and a relatively articulate subject, thereby limiting its utility as a research device.

To alleviate this procedural problem, Hays devised a self-administered, paper and pencil form of the measure, employing provided constructs most frequently elicited in the early studies (Hays, 1975). This provided form of the TI, the TIp, has been found to correlate highly with the elicited form, and to be independent of social desirability (Krieger, 1975).

Additionally, Hays examined the reliability and validity of the provided version. The TIp was discovered to have high internal consistency and high test-retest reliability over an interval of four weeks. Furthermore, Hays demonstrated the concurrent validity of the instrument by finding a moderate correlation with self-reported fear of personal mortality. Another examination of methodological validity was conducted in the Hays study, and was discussed by Krieger (1975, p. 47):

> A potential weakness of the original TI technique was that there was no way to check on the validity of a split to insure that a split on a given construct could legitimately be interpreted as an indication of death threat. It was reasoned that a split could justifiably be interpreted as threat if an element known to be threatening split on each construct while another element known to be non-threatening did not. Provision was made in the paper and pencil TI (TIp) for the inclusion of "comfortable" and "threatening" control elements, personally provided by each subject, to be placed on each construct in addition to the regular "self" . . . and "your own death" elements. After placement of the five elements on all 40 constructs, the first 24 "valid" constructs (constructs on which the "comfortable" element was placed on the same pole as self elements, while the "terrifying" element was placed on the opposite pole) were scored for death splits in the original procedure.

The scoring was found to be almost identical to the split score on all 40 constructs, thus lending support for the declaration that the splitting of self and death elements was, in fact, indicative of threat.

Rainey (1976) also found results supporting the validity of the TIp, revealing lower threat scores among thanatology students and death pre-planners (those who have arranged for the disposal of their body after death), than among adequate groups of controls. Moreover, he demonstrated the consistency of threat scores within the individual over a four month duration. These studies have provided convincing evidence for the construct validity and excellent temporal stability of the TIp.

Since its inception, the Threat Index has been employed in more than one dozen published investigations. The majority of

these studies have focused on delineating the psychometric adequacy of the instrument itself. At present, it is probable that the TI is the most carefully validated measure of death orientation in the literature to date (Neimeyer, Epting, and Krieger, 1984).

In sum, the research suggests that the Threat Index assesses a person's conceptual understanding of the way death relates to other aspects of his life. It may be viewed as a measure of more stable cognitive orientation regarding death than other instruments more specifically measuring anxiety and affective arousal regarding death (Rigdon, Epting, Neimeyer, and Krieger, 1979). Unlike the elicited form of the Threat Index, the TIp can be administered to individuals or large groups, and takes approximately 15 to 30 minutes to complete. Its advantages include ease of administration, standardization, and its allowance for between-subject comparisons. Limitations include the potentially impersonal format which may be objectionable to some respondents, and the lack of a conversational context to clarify the meaning of the constructs utilized (Neimeyer, Epting, and Rigdon, 1984). The TIp was used in the present study because of its administrative strengths and psychometric soundness.

Study Upon Which This Project is Based

Droogas, Siiter, and O'Connell (1983) investigated the effects of personal and situational factors on attitudes toward

suicide. The sample was comprised of 60 female and 20 male undergraduate volunteers enrolled at a state college. Subjects ranged in age from 19 to 57. In the study, each participant was presented with four contrived case histories, each depicting the situation and background of a person who committed suicide. The respondent then answered a series of 12 questions for each of the four vignettes.

The first of the four situations involved a description of a suicide precipitated by physical deterioration. The protagonist suffered from extensive paralysis resulting from a chronic condition of progressive neural degeneration (without pain). The next situation described a suicide of one undergoing physical pain, originating from an acute, non-crippling arthritis condition. The third account involved psychological deterioration, defined by a description of the pre-senile psychotic symptoms that characterize Alzheimer's disease. The final vignette illustrated psychological pain, wherein the suicidal protagonist was responsible for his wife's death in an automobile accident.

To test the hypothesis that those suicides of individuals who were more productive and useful to society would be less justifiable, four protagonist profiles were constructed. All of the characters were described as male and in their forties, to control for sex and age effects. A prominent scientist was portrayed as a biochemist conducting independent research in genetics. A middle-class citizen was depicted as an Army veteran who was the general

manager of a large supermarket. An ex-convict was presented as having served 20 years of a 25-year sentence for second degree murder, before being paroled. The fourth case involved an anonymous individual, with no background details provided.

Based on a review of the literature, the case histories were devised specifically for this study. The protagonist and situation components of each case history were randomly paired four times, yielding four combinations of the situation and protagonist levels, and a total of 16 specific case histories. Each one occupied one single-spaced typed page. Each case history was followed by the same set of 12 questions, which included ten six-point semantic differential items to be rated regarding the suicide: not justified/justified, cowardly/brave, foolish/wise, unnecessary/necessary, immoral/moral, inappropriate/appropriate, immature/mature, insane/sane, impulsive/rational, and selfish/unselfish. Low scores indicated unacceptability of suicide, while higher scores signified greater approval of the suicidal act.

Results were as follows: the students tended to regard psychological pain with less approval as a reason for suicide than either physical pain, mental deterioration, or physical deterioration; the mental deterioration situation did receive consistently lower ratings than the physical deterioration situation, indicating somewhat more acceptability of suicide because of physical deterioration; personal descriptions (social utility) had no overall effects on any of the measures, demonstrating that

students are probably more sensitive to the situation an individual is in than that individual's identity when expressing their attitudes toward suicide.

Limitations of the Droogas et al. Study

The acceptability of suicide as it varies with the nature of the precipitating trauma, whether physical or psychological, is an important issue warranting investigation. It is probable, however, that the Droogas, Siiter, and O'Connell study did not address this matter as claimed. Progressive neural degeneration (physical deterioration), acute, non-crippling arthritis (physical pain), and Alzheimer's disease (pyschological deterioration), all render the suicidal protagonists passive victims of a disease or other externally-derived set of circumstances. The male responsible for his wife's death in an automobile accident (psychological pain), however, was the only case in which the character had an active role in his suffering--he was presented as responsible. It is thus likely that the physical/psychological dimension was not being assessed because of this confound. Perhaps participants were responding to the responsibility attributable to each protagonist for the creation of the conditions culminating in suicide. The present investigation attempted to examine, in a controlled way, both the physical/psychological dimension, and the responsibility variable. Attribution theory provides a useful context with which to evaluate the responsibility factor.

Attribution Theory

Attribution is a person's perception of the reasons for other people's behavior. Our responses to other people depend on the attributions or inferences we make about their actions and intentions. The first person to study attributions systematically was Fritz Heider. His investigations led him to conclude that human beings try to discover ordinary or commonsense reasons for behavior--causality--in order to understand and predict events and to feel in control of our environment (Heider, 1944). Heider referred to this tendency to make commonsense attributions as "naive psychology" (Heider, 1958).

In making inferences in the absence of detailed information, we tend to rely on whatever information we do have, however limited it may be. Related to this, when we seek the causes and effects of actions and events, we are seeking a consistent way to attribute meaning. We assume that cause and effect go together, and that a modified cause will have an altered effect. We assume, then, that causes and effects will co-vary. Nevertheless, a given effect is usually the result of interaction among a number of causes (Kelly, 1967). Hence, there are deficiencies in attribution processes.

Confronted by the same information, do two people arrive at the same conclusions? Jones and Nisbett (1972) proposed that actors attribute their actions to situational factors, while observers attribute these same actions to personal dispositions.

Actors and observers view events from different perspectives, have different motivations, and have different information about the event and its participants as well. As actors, we have information about our own past behaviors and motivations, while as observers we do not know that much about the history of other people's behavior.

Another bias is the belief that we control events when in reality many of the events in our lives are likely to be determined by chance and external causes. Langer (1975) provided evidence to support the view that people attribute control to themselves or to others when the outcomes are unfavorable or even disastrous. Why should people want to assume blame for events that are clearly beyond their control? People need to believe they can control their own destinies, thus they prefer to view even a negative event as something that could have been controlled. It may be less disturbing to believe that an accident could have been prevented and to blame ourselves for not preventing it, than to believe that we could have done nothing to affect the outcome.

This perception is related to the "just world hypothesis" (Lerner, 1965). People want to believe that they live in a "just world" where good things happen to good people, and evil-doers get what they deserve. Walster (1966) presented subjects with a description of an accident: Lennie B parks his car on a hill, sets the handbrake, and leaves. Later the brake cable snaps and

the car rolls down the hill. Some subjects learned that the consequences of the accident were trivial (the car hit a tree stump and came to a halt), while others learned that the car was badly damaged. All of the subjects were asked to decide if Lennie had responsibility for the accident. Interestingly enough, the subjects assigned more guilt to Lennie when the consequences of the accident were great. The reasoning here appears to correspond to the just world hypothesis. I do not want an accident like this to happen to me. Therefore, I believe that accidents like this happen only to those who have done something wrong. Therefore, Lennie must be guilty of carelessness or negligence even if there is no evidence to support this (Schneider, Hastorf & Ellsworth, 1979). In a similar fashion, the present investigation examined the responsibility attributable to the suicide protagonist in relation to perceivers' appraisals of the completed suicides.

Hypotheses

Combining the research findings that comprise this review of the literature, the following hypotheses were constructed and tested by this study:

1. Suicides involving physical stressors will be perceived as more acceptable than suicides involving psychological stressors.
2. Cases in which the protagonist is responsible for the

conditions which led to the suicide will be perceived as more acceptable than suicides in which the protagonist is not responsible.

3. High death threat subjects will regard all suicides as less justifiable than low death threat subjects.
4. There will be no sex differences in responding.

CHAPTER III

METHODOLOGY

Sample

Students living in one residential area on the University of Florida campus participated in this investigation. This residential area is comprised of three college dormitories, each housing approximately 220 students. Males and females are distributed evenly throughout the three buildings. Approximately 85% of the 650 students living in the area are freshmen, and the vast majority of the remaining 15% are sophomores. Responses of juniors, seniors, and graduate students were discarded, so as not to bias the sample.

Each residence hall is co-educational, with alternating floors of males and females. Each floor of about 50 individuals has its own Resident Assistant, who is a student experienced in residence hall living. Resident Assistants are selected because of their superior leadership, academic, and interpersonal abilities. There are 12 Resident Assistants in the area, four per building, divided evenly among the sexes.

The three halls differ in no identifiable way from each other. There is considerable representation in terms of academic major, economic status, grade point average, religious affiliation, and ethnic background.

Table 1 includes the ages of subjects who participated. Table 2 provides a breakdown by sex of those who took part, and Table 3 describes the academic status of the respondents. In addition, Table 4 offers an analysis of those protocols which were not usable.

Table 3.1: Age of Subjects

Age	Frequency	Percent
17	4	1.5
18	145	54.3
19	97	36.3
20	19	7.1
21	1	0.4
26	1	0.4

Table 3.2: Sex of Subjects

Sex	Frequency	Percent
Male	134	50.2
Female	133	49.8

Table 3.3: Academic Status of Subjects

Class	Frequency	Percent
Freshman	210	78.7
Sophomore	57	21.3

Table 3.4: Unscoreable Protocols

Sex	Beyond Sophomore	No Death Element	Incomplete Death Element	Incomplete Responses to Suicide Cases	Total
Male	5	4	4	3	16
Female	11	5	5	1	22

Instrumentation

The materials administered to the students taking part in the study consisted of four specific items: 1) an introductory cover sheet (Appendix A), 2) a Declaration of Informed Consent Form (Appendix B), 3) a two-page version of the TIp, and 4) a four-page series of four suicide descriptions.

The introductory cover sheet served several functions. First, it introduced the student-examiner and identified the purpose of the study as attempting to explore college students' modes of response to suicide. Next, the cover letter invited the recipient to participate. If the individual did not wish to take part in the project, he was asked to return the materials. Particular demographic data were also requested: age, sex, and student status (for example, freshman, sophomore, etc.). The Declaration of Informed Consent is obvious in its purpose.

The principal investigator conducted a training session with the 12 Resident Assistants, who administered the packets to their respective floors. The staff was familiarized with the project and acquainted with the true nature of the variables to be investigated. Since the instructions were deemed by the investigator to be particularly straightforward and clear, the Resident Assistants were instructed to answer the majority of subjects' questions with the ambiguous response, "whatever you think is best", and were to ask the respondent to re-read the directions. When a question was

asked, the Resident Assistant was to walk to the inquiring individual and talk with that person one to one. In this way, extraneous comments would not influence other people's responses. If a Resident Assistant was confronted with an issue that he believed required resolution, the investigator was on call at a mutually agreed upon phone number to provide such resolution.

Administration was executed by the Resident Assistant staff, as opposed to the principal investigator, for several reasons. It was arranged so that all 12 floor meetings, which typically occur once monthly, took place simultaneously. In this way, potential confounds such as time of day, day of the week, and other subtleties could be held constant. More importantly, six of the 12 floors received different situations in the context of the responsibility variable.

The simultaneous administration insured that subjects from different floors did not talk to one another about the manipulated variables. The floor meetings were advertised four days prior as including discussion of upcoming floor events, housing administrative matters, and an opportunity to participate in the research of a current Hall Director (the principal investigator, whose job is to supervise the Resident Assistants and to address student concerns in a residence hall). It is believed that the quality of responses was not adversely affected by personal relationships the investigator has with some of the subjects; rather, it is felt that the desire to participate was enhanced.

Moreover, the execution of the project was the first order of business at the floor meeting. Those who did not wish to take part were invited to return in 20 minutes, after the administration was completed, when other matters more pertinent to the residence hall were to be communicated. The Resident Assistant then distributed the packets and pencils, read the introductory cover sheet, the Declaration of Informed Consent and the directions aloud, and completion of the packets by students followed. Four counselors were available during the administration in the event of any complicated reaction to the TIp or the suicide descriptions. Resident Assistants were instructed to call these counselors if they noticed such a reaction. In addition, all respondents were aware that trained personnel were available should they need to consult them.

Administration of the TIp

The TIp (40-item version) was presented prior to the suicide cases. If the Threat Index was presented after the vignettes, it was reasoned that the suicide descriptions would have had a more intense, emotional impact on the subjects, thereby influencing responding on the TIp. One would hypothesize that death threat would have been greater, as participants might have needed to defend against the psychic discomfort elicited by the previous exposure by construing self and death on opposite poles.

The initial presentation of the TIp was assumed to have a negligible effect on responses to the suicide cases. The nature of the instrument is such that the death element is most likely to be regarded by subjects as a hypothetical, intellectual exercise with no reality base, as each was asked to think of one's own death as if it were to occur at this time in one's life; while this measure stimulates one's imagination and intellectual faculties, the suicidal cases are more realistic and emotionally engaging.

Typical administration of the TIp includes separate pages for each of three elements. The first, the self element, requires that the subject circle the one adjective from each pair with which he sees himself or his present life more closely associated. Next, the ideal self element asks the participant to circle the side with which he more closely associates his ideal self, or the way he would prefer to be living. Finally, the death element calls for the respondent to indicate the pole with which he more closely associates his own death, considering his own death if it were to occur right now in his life. Since death threat was assessed by the number of splits on the self and death elements, it was reasoned that the preferred self element would have limited utility in the current investigation. For this reason it was not included (Appendix C).

Situations

All situations included protagonists who had completed suicide. Each subject read four different situations. In two of them, the precipitating trauma is physical in nature; the remaining two descriptions define the suicidal stressor as more psychological/emotional.

Each vignette was constructed to be as brief as possible, varying only the relevant variables so that all details of the account could be controlled. It is possible that the brevity of the cases encouraged an intellectualized and impersonal type of response, as the situations may have been perceived as unreal to respondents. To compensate for this possibility, the students were informed by the introductory cover sheet (which was read aloud by Resident Assistants to reinforce the importance of its contents), that the subsequent four case histories were taken from a national suicide prevention center, and that only minor details such as names and locations were changed to protect the identities of the individuals described. Subjects were also informed that the reasons for the suicides were validated by the suicide notes left by the four individuals.

Thus, each subject was presented with four case histories, two of which depicted a physical precipitant to suicide, and two that described a psychological/emotional trauma which culminated in suicide. Of the two physical situations, one concerned a protagonist who was responsible for the resultant trauma, while the

other depicted a protagonist who was in no way responsible for his condition. The same was true of the two psychological vignettes. One portrayed a character who was somehow responsible for the psychological trauma which confronted him, and the other described an individual who was in no way responsible.

Two forms were necessary to control for the responsibility variable. As an illustration, if on Form A, the protagonist was responsible in some way for developing cancer, Form B described this character as having in no way contributed to the cancer condition. Form A was given to one-half of the respondents, while the remaining half received Form B. All respondents received a physical-responsible situation, a physical-not responsible situation, a psychological-responsible situation, and a psychological-not responsible situation.

One situation on Form A describes a protagonist as having to be confined to a wheelchair:

John B., a 44 year-old male, was riding his bicycle on the walkway of a bridge when three delinquent youths pushed him over. He fell into very shallow water and was paralyzed from the waist down. He would be confined to a wheelchair for the rest of his life. John B. killed himself, deciding he could not live that way. (physical-not responsible)

This situation presented on Form B read:

John B., a 44 year-old male, got drunk and dove off the side of a bridge into very shallow water; he was paralyzed from the waist down. He would be confined to a wheelchair for the rest of his life. John B. killed himself, deciding he could not live that way. (physical-responsible)

The other situation depicting physical stress on Form A involves a protagonist suffering from lung cancer:

Richard S., a 40 year-old man, had been smoking two packs of cigarettes a day for the last 20 years, despite constant warnings from doctors to quit. After a routine physical examination, his doctors informed him that he had lung cancer. Several months later, he decided to kill himself to avoid the excruciating pain. (physical, responsible).

On Form B, this situation read:

Richard S., a 40 year-old man, was warned by doctors that the form of cancer his father died from might be hereditary. Because of this, he exercised daily and was careful to eat a well-balanced diet. After a routine physical examination, which he received yearly, his doctors informed him that he had cancer. Several months later, he decided to kill himself to avoid the excruciating pain. (physical-not responsible)

On Form A, a protagonist undergoing psychological pain was described:

After a car mechanic had reported his automobile to be in perfect working order, Thomas P., a 42 year-old male, was driving his car when the brakes gave way. He turned off the road and crashed into a tree. Thomas P. was thrown clear, but his wife burned to death. About a year after her death, on their anniversary, his guilt caused him to kill himself. (psychological-not responsible)

On Form B, this situation was changed to:

After a car mechanic had reported faulty brakes on his automobile, Thomas P., a 42 year-old male, made no attempt to repair them. While subsequently driving with his wife, the brakes gave way; he turned off the road and crashed into a tree. Thomas P. was thrown clear, but his wife burned to death. About a year after her death, on their anniversary, his guilt caused him to kill himself. (psychological-responsible)

The fourth situation, appearing on Form A, read:

After Harold F., a 44 year-old man, gambled the family's savings away, his wife left him, taking the children with her. A year and a half later, he was still struggling with his depression, and after repeated but unsuccessful attempts at reconciliation, he killed himself. (psychological-responsible)

On Form B, this case appeared as:

> After losing a large sum of money when the stock market unexpectedly crashed, the wife of Harold F., a 44 year-old male, left him for another man, taking the children with her. A year and a half later he was still struggling with his depression, and after repeated but unsuccessful attempts at reconciliation, he killed himself. (psychological-not responsible)

Whereas psychological or emotional pain is often perceived as temporary, physical pain associated with a long-term condition or incurable disease may be viewed as more permanent (Droogas, Siiter, and O'Connell, 1983). In the present study, the protagonists' despair in the psychological situations was extended over a protracted period of time to evidence its resistance to the ameliorative influences of time and experience.

In order to assess how respondents regarded each suicide, a technique used in the Droogas, Siiter, and O'Connell study (1983) was employed. Ten polarized word pairs follow each case history: not justified/justified; cowardly/brave; foolish/wise; unnecessary/necessary; immoral/moral; inappropriate/appropriate; immature/mature; insane/sane; impulsive/rational; and selfish/unselfish. Students' reactions to this semantic differential were scored from one to six, with lower scores indicating a negative attitude toward a particular suicide ("foolish"), while higher scores evidenced a more positive attitude ("wise"). For each suicide case, the means for each of these word pairs were calculated, and the ten derived means were summed. Lower cumulative means were indicative of unacceptability of a given suicide.

Order

Ideally, the sequence of case histories would have been randomized for each student. Four vignettes can be assorted into 24 different orders. Of these 24, 12 would need to have been selected from a table of random numbers, given that 12 floors were involved. The responsible/not responsible, and male/female variables would have increased the number of cells to the point where the study would not have been feasible.

Rather than eliminate a variable, absolute systematic control over the sequencing of vignettes was compromised. From a table of random numbers, the four situations were assorted once, being held constant for all subjects. There were two forms (A and B), with the wheelchair, cancer, car accident, and fleeing wife situations occurring in the same order on both. However, if on Form A the wheelchair situation involved a protagonist who was not responsible, Form B presented that character as reponsible. This method made the project more manageable, without sacrificing a potentially rich variable. It is recognized, nevertheless, that responses to the car accident case may have differed as a function of whether the wheelchair or cancer case preceded it, as an example (Appendices D and E).

Within each building, one of the two male floors received Form A, the other B, and one of the female floors received Form A, and the other B. Which male/female floor received which form was randomly decided. Randomization of forms was done within each building rather than across all three, since it may be the case

that the Resident Assistants in one building are more similar to one another than those in other buildings, as they spend more time with one another and are supervised by the same individual. Hence, both sexes were administered all variations of the form within each dormitory to control for possible administrator biases. Three male floors received Form A, and three received Form B; three female floors received Form A, and the remaining three received Form B.

Procedure

The procedure is now presented graphically.

Building I			Building II			Building III		
Floor	Sex	Form	Floor	Sex	Form	Floor	Sex	Form
1	M	A	1	M	B	1	F	B
2	F	A	2	F	A	2	M	A
3	M	B	3	M	A	3	F	A
4	F	B	4	F	B	4	M	B

Debriefing

Following the administration, the Resident Assistants explained the true nature of the research to the students, including a description of the relevant variables investigated.

Additionally, subjects were informed that the cases were fictitious, and did not come from the files of a national suicide prevention center. The principal investigator's name, address, and phone number were offered, and all who participated were thanked. Respondents were also told that a process group would be scheduled two days after the administration, to discuss the project and the issue of suicide in general. This session was to be led by the investigator; no one attended, however.

CHAPTER IV

RESULTS

A two between subjects, two within subjects analysis of variance was conducted to analyze the data (2 x 2 x 2 x 2). Between refers to the subjects' capacity to vary on these dimensions. The two between factors were sex and form, each having two levels (male or female, and Form A or Form B). The two within factors included the physical/psychological variable, and the responsible/not responsible variable. These are within factors because every respondent was exposed to physical and psychological, as well as responsible and not responsible situations.

Scores on the Threat Index were computed by calculating the number of discrepancies on the death and self elements. A larger number of discrepancies indicates a greater degree of death threat. The average score in this sample was 22.18 (Male M = 21.86; Female M = 22.50). Rigdon, Epting, Neimeyer, and Krieger (1979) reported a mean of 19.30 when the subjects were introductory psychology students, and 20.81 when the subjects were physicians, lawyers, and students preparing for those professions.

Overall acceptability scores for the suicide cases were calculated by summing the ten scores from the ten semantic differential word pairs following each suicide presentation.

Higher scores indicated a greater acceptance of the suicide, whereas lower scores signified a greater degree of unacceptability.

A Pearson product-moment correlation between death threat and overall suicide acceptability was significant ($r = .08$, $p<.01$). Thus, overall, subjects who were more threatened by death were more likely to view the presented suicides as more acceptable. However, the correlation was quite small, thereby curtailing any especially psychologically meaningful interpretation. For this reason, correlations between death threat and suicide acceptability were conducted with all significant effects only.

Tables 4.1 and 4.2 include results for all between subjects and within subjects effects, respectively. A significant main effect for sex was discovered, indicating that, overall, males and females did not view suicide with the same level of acceptability, $F(1,251) = 5.52$, $p<.05$. Post-hoc t-tests revealed that males perceived suicide as significantly more acceptable ($M = 25.54$; $SD = 8.23$) than females ($M = 23.29$; $SD = 7.63$), overall. Pearson product-moment correlations indicated that there was no significant relationship between the level of death threat and the degree of suicide acceptability for either males or females.

Table 4.1. Tests of Hypotheses for Between Subjects Effects

Source	DF	MS	F Value
Sex	1	1356.7954	5.52*
Form	1	414.8309	1.69
Sex x Form	1	1479.4963	6.02*
Error	251	245.9159	

*$p<.05$

Table 4.2. Univariate Tests of Hypotheses for Within Subjects Effects

Source	DF	MS	F Value
Phy Psy	1	9265.6612	108.21*
Phy Psy x Sex	1	227.8891	2.66
Phy Psy x Form	1	159.9778	1.87
Phy Psy x Sex x Form	1	10.4422	0.12
Error (Phy Psy)	251	85.6231	
Source	**DF**	**MS**	**F Value**
Resp	1	167.6349	2.68
Resp x Sex	1	3.7606	0.06
Resp x Form	1	200.8674	3.21
Resp x Sex x Form	1	63.8105	1.02
Error (Resp)	251	62.6658	
Source	**DF**	**MS**	**F Value**
Phy Psy x Resp	1	364.7883	5.71*
Phy Psy x Resp x Sex	1	6.8877	0.11
Phy Psy x Resp x Form	1	1218.4384	19.06*
Phy Psy x Resp x Sex x Form	1	5.2663	0.08
Error (Phy Psy x Resp)	251	63.9219	

*$p<.05$

These results must be viewed tentatively, since a significant interaction between sex and form was found, $F(1,251) = 6.02$, $p<.05$. Thus, males' and females' acceptability of suicide varied depending on whether they responded to Form A or Form B. The forms were assumed to be different only in that the protagonists described as responsible for their fate on one form were portrayed as not responsible on the other form. Each form had two protagonists who were responsible and two who were not.

Post-hoc t-tests revealed that males on Form B found suicide to be more acceptable ($M = 27.39$; $SD = 9.43$) than males on Form A ($M = 23.69$; $SD = 6.36$), whereas females on Form A were not significantly different in acceptability ($M = 23.80$; $SD = 7.19$) from females on Form B ($M = 22.66$; $SD = 8.17$). Thus, something specific to Form B made males perceive the suicides described as more acceptable than those males responding to suicides presented on Form A.

In addition, males on Form B regarded the suicides presented as significantly more acceptable ($M = 27.39$; $SD = 9.43$) than females on Form B ($M = 22.66$; $SD = 8.17$), whereas males on Form A did not differ significantly ($M = 23.69$; $SD = 6.36$) from females on Form A ($M = 23.80$; $SD = 7.19$). These findings indicate that something specific to Form B made males perceive the suicides described as more acceptable than females. Figure 4.1 depicts this finding.

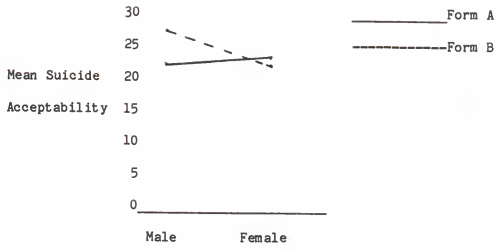

Figure 4.1. Sex X Form Interaction

To determine exactly which vignettes on which forms were responsible for these differences, the means for each situation, by sex, were computed and analyzed. Table 4.3 includes these findings.

Table 4.3. Means for Each Situation by Sex

Form A	Male	Female
Situation 1 (wheelchair-not responsible)	27.93	27.45
Situation 2 (car accident-not responsible)	21.05	22.96
Situation 3 (cancer-responsible)	27.35	26.89
Situation 4 (fleeing wife-responsible)	19.25	19.12
Overall Mean	23.69	23.80
Form B	**Male**	**Female**
Situation 1 (wheelchair-responsible)	28.47	23.40*
Situation 2 (car accident-responsible)	25.82	22.50
Situation 3 (cancer-not responsible)	32.93	25.91*
Situation 4 (fleeing wife-not responsible)	23.09	18.56*
Overall Mean	27.39	22.66*

*$p < .05$

Table 4.3 indicates that males and females did not perceive as significantly different in acceptability any of the four suicide situations on Form A. On Form B, however, three of four situations were perceived as significantly more acceptable to males than females. Something specific to these three vignettes made the suicides more acceptable to males. These results suggest that the two forms were unexpectedly different from one another on variables other than the responsibility attributed to each protagonist for each situation.

Correlations were conducted between death threat and males, for each form, and death threat and females, for each form. Significant results indicate that high death threat males were more likely to perceive suicide as more acceptable on Form B ($r = .26$, $p<.05$).

A significant main effect was also discovered for the physical/psychological variable $F(1,251) = 108.21$, $p<.05$. This means that subjects' ratings of suicide acceptability varied depending on whether the situation was physical or psychological. Post-hoc t-tests revealed that suicides involving physical traumas were significantly more acceptable ($M = 27.62$; $SD = 10.36$) than suicides involving psychological stressors ($M = 21.47$; $SD = 8.14$). Correlations between death threat and physical situations, and death threat and psychological situations, yielded no significant findings. Thus, subjects' level of death threat did not relate to their ratings of acceptability for either physical or psychological suicide situations.

A significant interaction was found between the physical/psychological and the responsibility variables, $F(1,251) = 5.71$, $p<.05$. This indicates that for certain physical and/or psychological situations, whether or not the protagonist was responsible for his condition affected subjects' ratings of suicide acceptability. Post-hoc t-tests revealed that physical-not responsible cases were perceived as significantly more acceptable ($M = 28.61$; $SD = 12.81$) than physical-responsible situations ($M = 26.64$; $SD = 11.45$), whereas for psychological situations, there were no such differences between not responsible ($M = 21.57$; $SD = 9.58$) and responsible ($M = 21.58$; $SD = 9.69$) cases. This means that, overall, the responsibility variable affected ratings of suicide acceptability only in physical situations, with not responsible cases perceived as more acceptable than responsible suicides. Responsibility did not interact with psychological situations, overall. These results must be viewed tentatively, since a significant interaction was obtained between physical/psychological, responsibility, and form.

Moreover, physical-not responsible cases were significantly more acceptable ($M = 28.61$; $SD = 12.81$) than psychological-not responsible cases ($M = 21.57$; $SD = 9.58$), and physical-responsible cases were significantly more acceptable ($M = 26.64$; $SD = 11.45$) than psychological-responsible cases ($M = 21.58$; $SD = 9.69$). Thus, physical suicide situations were evaluated as more acceptable than psychological suicide situations, regardless of whether the suicidal protagonist was responsible for his state. Figure 4.2 depicts this finding.

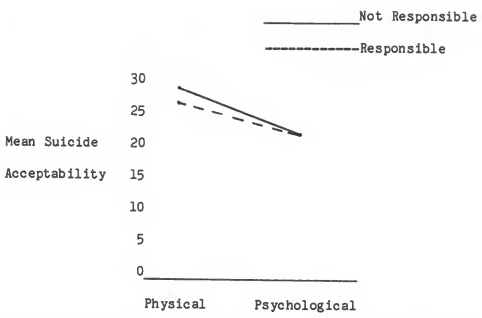

Figure 4.2. Physical/Psychological X Responsibility Interaction

Correlations between death threat and physical-responsible, physical-not responsible, psychological-responsible, and psychological-not responsible cases were computed. A significant finding indicated that high death threat individuals were more likely to regard physical-responsible suicide cases as more acceptable ($r=.18$, $p<.05$).

A significant interaction effect was found between the physical/psychological, responsibility, and form dimensions, $F(1,251) = 19.06$, $p<.05$. This means that particular combinations of physical/psychological situations, responsible and not responsible protagonists, and Form A and Form B, yielded different levels of suicide acceptability. Post-hoc t-tests revealed that on Form A,

the psychological-not responsible case was perceived as significantly more acceptable (M = 22.08; SD = 8.78) than the psychological-responsible case (M = 19.19; SD = 7.51), whereas no such significant differences were revealed for physical-not responsible (M = 27.68; SD = 11.50) and physical-responsible cases (M = 27.11; SD = 11.46). Thus, on Form A, the responsibility dimension affected acceptability ratings for psychological, but not physical suicides.

On this same form, the physical-responsible situation was significantly more acceptable (M = 27.11; SD = 11.46) than the psychological-responsible case (M = 19.19; SD = 7.51), and the physical-not responsible case was significantly more acceptable (M = 27.68; SD = 11.50) than the psychological-not responsible case (M = 27.08; SD = 8.78). Therefore, on Form A, physical situations resulting in suicide were more acceptable than psychological situations, regardless of whether the protagonist was responsible for his misfortune.

On Form B, the physical-not responsible case was significantly more acceptable (M = 29.67; SD = 14.13) than the physical-responsible case (M = 26.08; SD = 11.45), but the psychological-responsible suicide was significantly more acceptable (M = 24.31; SD = 11.10) than the psychological-not responsible suicide (M = 21.01; SD = 10.42). This finding illustrates that on Form B, the level of responsibility attributable to the suicidal protagonist affects one's evaluation of suicide acceptability, depending on whether the situation is physical or psychological in nature.

Furthermore, the physical-not responsible suicide was perceived as significantly more acceptable (M = 29.67; SD = 14.13) than the psychological-not responsible suicide (M = 21.01; SD = 10.42). While no significant differences were found between the physical-responsible (M = 26.08; SD = 11.45) and psychological-responsible cases (M = 24.31; SD = 11.10), the means were in the expected direction, with physical situations having a higher rating. Thus, on Form B, physical situations resulting in suicide were either significantly more acceptable than psychological situations, or were approaching significance in that direction. Figure 4.3 illustrates these results.

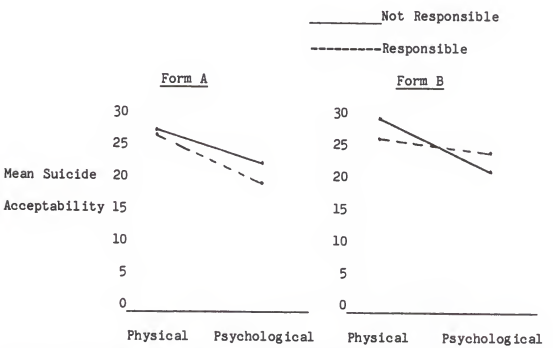

Figure 4.3. Physical/Psychological X Responsibility X Form Interaction

Correlations between death threat and each of the four categories on Form A (physical-responsible, physical-not responsible,

psychological-responsible, psychological-not responsible) were conducted. A significant but small correlation was found between death threat and the physical-responsible situation on this form ($r=.17$, $p<.05$). Thus, high death threat individuals were more likely to rate the physical-responsible case on this form as most acceptable.

The same operation was conducted for Form B, and a significant but small correlation was found between death threat and the same category, physical-responsible ($r=.19$, $p<.05$), indicating that high threat individuals on this form were more likely to regard this suicide as most acceptable.

CHAPTER V

EVALUATION OF THE RESULTS

The hypothesis that people would manifest different attitudes toward suicides that occur in response to extreme life circumstances was supported by the data. The findings that certain suicide cases were perceived as more acceptable than others indicates that suicide is interpreted in terms of the context of each case, thereby eliciting varying levels of acceptability.

The first hypothesis, that college students would respond in a more tolerant and accepting way when the suicide involves a protagonist confronted with a severe physical, rather than psychological precipitant, was strongly supported. Respondents to Form A perceived physical-not responsible suicides as significantly more acceptable than psychological-not responsible suicides, and physical-responsible suicides as more acceptable than psychological-responsible cases. On Form B, physical-not responsible suicides were significantly more acceptable than psychological-not responsible suicides, but there was no perceived significant difference between physical and psychological suicides in the context of responsible protagonists. However, the actual difference, albeit not significant, was in the expected direction, as these physical cases had a higher mean acceptability score.

Psychological pain is often perceived as transient or temporary. The pain that results from guilt or grief is usually seen as amenable to amelioration through experience, treatment, or time. Physical pain associated with an incurable, long-term disease or condition may be viewed as a more permanent state, for which suicide is sometimes an "acceptable" solution. The psychological situations in the present study extended the protagonists' despair over a period of time to emphasize its resistance to healing influences. Despite this loading, these situations were still regarded by students as less justifiable and more bearable than the physical situations. This replicates the findings of Droogas, Siiter, and O'Connell (1983).

It is tenable that the students in the present study were not able to identify with the psychological pain of the protagonists who had lost their wives either by death (car accident situation) or abandonment (feeling wife situation). Perhaps the fact that the individuals in the sample don't have wives or are not wives themselves may explain this result. Furthermore, while physical pain and suffering is understood and perceived as highly undesirable by most people (Cappon, 1970; Staninger and Colsher, 1979; Welu, 1972), psychological pain is a private experience that may lack a visible, tangible, or verifiable objectivity. Thus, it is feasible that people are generally less responsive toward mental suffering than they are toward physical suffering because they are less sensitive to or less able to identify with the genuine misery of psychological anguish.

The second hypothesis, that suicides involving protagonists who were responsible for the events leading up to the suicide would be deemed more acceptable than those suicides involving individuals who were not responsible, was not upheld in terms of overall main effects. However, there was a significant interaction effect between responsibility, physical/psychological, and form. This indicates that for some physical/psychological situation on some specific forms, the responsibility dimension was differing significantly.

On Form A, the psychological-not responsible case was more acceptable than the psychological-responsible suicide. However, on Form B, the physical-not responsible case was more acceptable than the physical-responsible suicide, and the psychological-responsible case was more acceptable than the psychological-not responsible one. These differences are not consistent with the responsibility hypothesis. Perhaps a dimension unrelated to responsibility and more closely associated with idiosyncratic situational factors can explain this finding.

The psychological-not responsible case on Form A, and the physical-not responsible and psychological-responsible cases on Form B, all judged as more acceptable, have one common denominator. The psychological cases both involved the car accident scenario in which the protagonist's wife dies. The physical case cited depicts an individual afflicted with cancer, whose father, it states, died of this same condition. Hence, these situations were different from all others in that the

suicides were related in some way to the losses of loved ones by death. It is quite possible that this unique feature intensified the already tragic suicide of each protagonist, stimulated respondents to perceive the existence of an especially formidable state of crisis in the protagonists' lives, and thus enabled subjects to readily accept as more justifiable their "solution" of suicide.

These findings seem to suggest that the attribution of responsibility may not be present in a suicide assessment task. Subjects seemed to be more attuned to the plight in which the individual finds himself rather than how the conditions or events which resulted in the situation came to be when appraising the acceptability of a given suicide. Furthermore, what may well be the single most important criterion for judging the "appropriateness" of the individual's death, namely that individual's age (Sudnow, 1967; Roth, 1978), was controlled in the fictional case histories and, consequently, could not influence differences among responses to the protagonists.

The third hypothesis, that death threat would be inversely correlated with perceived suicide acceptability, was not supported. Instead, a very small, directly proportional relationship was found. Another meaningful result for discussion is the also small but significant positive relationship between death threat and acceptability of physical-responsible suicides across forms. This result may have accounted for the overall significant finding, as death threat did not correlate with physical-not

responsible, psychological-responsible, or psychological-not responsible cases.

There may be a strong influence on the overall direction of the students' responses. The case histories as presented were simply histories. The respondents were evaluating something that had already happened, that could not be reversed, and that could be regarded objectively, without guilt, with fewer moral or ethical constraints, and with less of an inclination to preserve life.

It is plausible that high death threat individuals need to justify acts that have already been committed, perhaps because they are people who need greater cognitive control over events. To squarely confront the uncertainty, randomness, and ambiguity of profound life/death concerns might be intolerable for these people. By definition, high death threat individuals have more difficulty with integration, namely of death as a part of life. It is interesting to speculate that responses would have differed had the histories depicted protagonists who were contemplating suicide, rather than a post-hoc assessment. It must be noted, however, that high death threat scores correlated in a very minor way to suicide acceptability. Thus, the hypothesis offered may have limited explanatory power.

Krieger, Epting, and Leitner (1974), and Rigdon, Epting, Neimeyer, and Krieger (1979), discovered that high death threat individuals were less able to conceive of their own mortality.

They reasoned that regarding oneself as virtually immortal appears to be suggestive of a fundamental flaw in one's conception of human reality. This may help to explain the significant positive relationship between death threat and acceptability of physical-responsible suicide cases. One of these cases involved a protagonist who got drunk, jumped off a bridge, and would have been confined to a wheelchair had he not killed himself. The other case involved a protagonist who had been smoking two packs of cigarettes daily for 20 years before developing lung cancer. These two cases, more so than the others, portrayed characters involved in activities most explicitly depicted as destructive. Protagonists acted with an almost narcissistic disregard of consequences, ignoring the likely outcomes of jumping off a bridge and smoking two packs of cigarettes a day for 20 years.

It can be argued that there was no correlation between death threat and the situation involving the protagonist who acted with this same "it-can't-happen-to-me" attitude when he drove a car with faulty brakes, despite a mechanic's warning. However, the extent of the brake's damage was not as explicitly stated; only after the accident could one surmise that the degree of damage was great. This situation differs from the two physical-responsible cases in that the consequences of these characters' actions were easier to discern prior to the occurrence of the tragedy itself.

In the same way that high death threat individuals have difficulty accepting their own mortality, so did the protagonists in these most acceptable suicides deny their human constraints.

It is possible that these two physical-responsible cases were more personally threatening to the high threat subjects. Agreeing with the protagonists' decisions to kill themselves in these vignettes might have served a self-protective function. Questioning the completed suicies would lead to greater self-exploratin and pose a substantial threat to a cognitive system which may need to rationally control events that have already occurred. Thus, because of the potential similarity between respondents and protagonists, the need not to question and explore the suicide post-hoc could have been stronger than the impetus to risk cognitive disorganization for high threat students.

An alternative explanation might be that these students, because of the perceived similarity, were better able to identify with the tragic events in the lives of these protagonists. This identification enabled them to readily accept as more justifiable their "solutions" of suicide, thus penetrating the protective defensive operations. The data suggest, then, that for high death threat individuals, those suicides judged most acceptable involve people who, like themselves, cannot conceive of their own mortality.

The final hypothesis, that no sex differences in responding would be found, was generally not supported. An overall main effect indicated that males perceive suicide as more acceptable than females. However, an interaction between sex and form revealed that on Form B, males regarded suicide as more acceptable than females, but on Form A, no such differences existed. Hence,

something particular to Form B made suicide more acceptable to males than females, and males' appraisals on Form A.

An analysis of the situations within each form indicated that on Form A, males' and females' acceptability judgements were not significantly different from one another on any of the four situations. On Form B, however, males judged as significantly more acceptable three of the four vignettes: the wheelchair, cancer, and fleeing wife scenarios.

If one were to examine these three portrayals on each form and combine them into a single profile, differences become obvious. The composite of Form A would be a male who lives in an area where delinquent youth have access, who has smoked two packs of cigarettes a day for 20 years, and who gambles. The profile comprised of these three situations on Form B portrays a male who defies his human and mortal limits by diving off a bridge when drunk, who takes care of his body through regular exercise and proper diet, and who invests in the stock market (a particularly middle-class venture). The first profile elicits an image of an unrefined, unsophisticated, and lower-class individual. The second composite evokes an image of a more refined, sophisticated, and middle-class character.

Given that the socioeconomic status of the families of respondents in this sample is well above the national average, it is quite likely that they were better able to identify with the lifestyles of the characters in Form B. Moreover, feelings of being able to transcend human constraints, and concern with body image

and legitimate money acquisition seem to be typical issues for late adolescent, middle-class males. Since all the protagonists who killed themselves were men, the sense of identification was intensified. It is likely that the level of acceptability would have been different had the protagonists been female. Thus, it is reasoned that the male subjects identified with the male protagonists in these situations because of a perceived similarity to themselves.

As a result of this capacity to identify more fully, the suicides were more acceptable because the misfortunes of the protagonists became more emotionally-engaging and personally meaningful. Perhaps females' ability to identify was limited in these situations because of the sex of the protagonists, as well as their particularly "male" characteristics. It is proposed then, that males evaluating suicides involving individuals similar to themselves will regard these suicides as most acceptable. Too close a resemblance, however, may be threatening.

Conclusions and Implications

The result that physical problems are seen as more serious justifications for suicide than mental or psychological problems, implies that the person who attempts suicide because of emotional problems is perhaps irrational and irresponsible, whereas the individual who attempts suicide because of physical or medical trauma may be behaving more rationally. In other words, there is the implicit assumption that one confronted with

overwhelming physical pain can somehow think, reason, and behave more rationally than someone confronted with psychological pain.

In general, the data also indicate that students are potentially more sensitive to the situation an individual is in than the circumstances which brought about the situation when expressing their attitudes toward suicide. Theoretically, it is interesting to note that the need to attribute responsibility may vary with the type of phenomena being addressed. Suicide, it seems, is a phenomena that does not have an attribution demand.

The last two findings suggest that the greater the degree of similarity between the perceiver and the person committing suicide, the more acceptable will that suicide be to the perceiver. As an illustration, suicides evaluated as most justifiable by high death threat individuals involved people who, like themselves, had difficulty conceiving of their own mortality. Related to this, males in this sample perceived those suicides involving individuals like themselves as most acceptable. These findings have potentially worthwhile implications for the training of volunteers in a suicide prevention center, future therapists, and individuals in the community.

Further research is essential to delineate the relationship between one's perceived acceptability of a suicidal response to crisis and the manner in which one interacts or works with the individual confronting the situation. If one is especially more accepting and empathic to the plight of a suffering person because of one's own issues, will interactions/interventions reinforce the

suicidal wish in subtle ways? Might interventions differ between one who does not project his personality onto the situation and one who does?

Related to this, does one's level of acceptability differ for people who have already committed the act and those seriously considering it? It has been found that tolerance for suicide decreases markedly when emotional attachments are involved and the potential loss of a loved one has direct impact on the individual (Frederick, 1971). The present research posed completed, irreversible suicides which permitted evaluation from a distance. The task involved making judgements of more or less abstract situations on the basis of ideological principles. This context is undeniably different from the volunteer worker, therapist, or individual in a community working directly with a suicidal person. In the former situation, the human involvement and sense of immediacy are lacking. Projects addressing these matters are needed.

Limitations

As stated, a major limitation of this investigation is its focus on completed suicides. It is therefore difficult to propose training and practice implications, since these issues largely involve prevention of the act before it occurs. As discussed previously, prevention and post-hoc assessment are two entirely distinct phenomena.

The generalizability of the findings may be quite limited, as 18 and 19 year-old students responded to the suicides of 40-44 year-old males. In addition, the socioeconomic status of individuals in the sample is well above the national average, thereby diminishing the external validity of the results.

The order in which the situations were presented might have affected responses. Acceptability of the car accident case may have differed as a function of whether the wheelchair or cancer case preceded it, as an example. This type of subtle influence is difficult to determine, but its presence is quite possible.

Another limitation is the manner in which the case material was presented. Hart (1979) demonstrated that a videotaped presentation of a burn victim requesting the termination of life-saving treatment effected a shift toward a more favorable view of euthanasia, while a written narrative of the same situation induced a shift in attitude toward a less favorable view. It appears that the videotape was a far superior communicator of the burned victim's dilemma than the written narration. The present study stimulated a more intellectual form of response, and empathy for the protagonist's situation was consequently curtailed.

Finally, the two forms administered were qualitatively different, inadvertently assessing different issues. One form elicited sex differences while the other did not; one form depicted more middle-class protagonists, while the other portrayed a series of less refined and lower-class characters. It was not considered that modifying the presumed level of responsibility

potentially altered other factors such as the perceived socio-economic status of the protagonist, plausibility of the situation, similarity between the protagonist and respondent, capacity to identify with the respondent, and probably a host of other subtleties. More studies are needed to control for these effects.

The present study has examined the influence of the suicidal situation on college students' attitudes toward suicide when evaluating case histories of male protagonists. Further research is needed to ascertain whether responses would have differed had suicide been presented as considered by people in crisis instead of completed. Additionally, projects using female as well as male case histories to determine if female protagonists elicit the same kinds of judgements as males need to be conducted. Further research is also needed with protagonists of various ages and with non-college as well as college populations.

APPENDIX A
INTRODUCTORY COVER SHEET

I am conducting a study on suicide. Only your opinions about death and suicide are required, and both participation and completion of the materials are entirely optional. This booklet contains a survey regarding how you view your own life and your own death. In addition, four case descriptions of suicide will be presented and you will be asked to rate them. This will take approximately 20 minutes of your time.

If you agree to participate, please fill out the information below, then turn to the Declaration or Informed Consent. If you are not willing to participate, I would appreciate your return of this packet for use elsewhere.

Thank you for your cooperation.

Sincerely,

Michael Steinberg

Demographic Information

Age _____

Sex _____

Circle One: Freshman Sophomore Junior Senior Other

APPENDIX B
DECLARATION OF INFORMED CONSENT FORM

Informed consent is given to participate in this study of how college students perceive suicide. Publication of study results is permissible so long as the information remains anonymous. All precautions have been taken to protect anonymity, and there is no way that the identity of the respondents can be determined.

1) The general purpose of this study is to identify how college students perceive suicide.

2) There are no known expected risks or discomforts involved in my participation.

3) The investigator will answer any questions regarding the procedures of this study.

4) Freedom to withdraw participation at any time exists, without prejudice.

5) No monetary compensation is involved in participation.

6) Consent to participate in this procedure has been given, and a copy of this description has been received.

If there are any questions, please feel free to contact the investigator, Michael Steinberg, at 395-8940, or the Psychology Building, Box 120.

_____ _____

Participant Date

APPENDIX C
THE THREAT INDEX (TIp40)

Self element. Below is a list of dimensions, each of which is made up of a pair of opposites. For each dimension, please circle the side with which you see yourself or your present life more closely associated. In some cases, you may feel as if both sides describe you to some degree, but please circle only one side of each dimension: the one that describes you better. For example, do you see yourself as more predictable or more random?

predictable-random

empty-meaningful

lack of control-control

satisfied-dissatisfied

relating to-not relating
others to others

pleasure-pain

feels bad-feels good

objective-subjective

alive-dead

helping others-being selfish

specific-general

kind-cruel

incompetent-competent

insecure-secure

static-changing

unnatural-natural

calm-anxious

easy-hard

productive-unproductive

learning-not learning

sad-happy

personal-impersonal

purposeful-not purposeful

responsible-not responsible

bad-good

not caring-caring

crazy-healthy

conforming-not conforming

animate-inanimate

weak-strong

useful-useless

closed-open

peaceful-violent

freedom-restriction

nonexistence-existence

understanding-not understanding

sick-healthy

stagnation-growth

abstract-concrete

hope-no hope

Death element. For each of the dimensions below, please circle the side with which you more closely associate your own death, thinking of your own death as if it were to occur at this time in your life.

predictable-random

empty-meaningful

lack of control-control

satisfied-dissatisfied

relating to-not relating to others

pleasure-pain

feels bad-feels good

objective-subjective

alive-dead

helping others-being selfish

specific-general

kind-cruel

incompetent-competent

insecure-secure

static-changing

unnatural-natural

calm-anxious

easy-hard

productive-unproductive

learning-not learning

sad-happy

personal-impersonal

purposeful-not purposeful

responsible-not responsible

bad-good

not caring-caring

crazy-healthy

conforming-not conforming

animate-inanimate

weak-strong

useful-useless

closed-open

peaceful-violent

freedom-restriction

nonexistence-existence

understanding-not understanding

sick-healthy

stagnation-growth

abstract-concrete

hope-no hope

APPENDIX D
FORM A

Directions

The following four case studies were taken from the files of a national suicide prevention center; only minor details such as names and locations were changed to protect the identities of the individuals presented. The reasons for the suicides were validated by the suicide notes left by the four individuals. Please read everything carefully, answer the questions honestly, and do not go back to earlier items.

attempts at reconciliation, he killed himself.

Please circle a number from 1 to 6.
Was this suicide:

not justified	1	2	3	4	5	6	justified
cowardly	1	2	3	4	5	6	brave
foolish	1	2	3	4	5	6	wise
unnecessary	1	2	3	4	5	6	necessary
immoral	1	2	3	4	5	6	moral
inappropriate	1	2	3	4	5	6	appropriate
immature	1	2	3	4	5	6	mature
insane	1	2	3	4	5	6	sane
impulsive	1	2	3	4	5	6	rational
selfish	1	2	3	4	5	6	unselfish

John B., a 44 year-old male, was riding his bicycle on the walkway of a bridge when three delinquent youths pushed him over. He fell into very shallow water and was paralyzed from the waist down. He would be confined to a wheelchair for the rest of his life. John B. killed himself, deciding he could not live that way.

Please circle a number from 1 to 6.
Was this suicide:

not justified	1	2	3	4	5	6	justified
cowardly	1	2	3	4	5	6	brave
foolish	1	2	3	4	5	6	wise
unnecessary	1	2	3	4	5	6	necessary
immoral	1	2	3	4	5	6	moral
inappropriate	1	2	3	4	5	6	appropriate
immature	1	2	3	4	5	6	mature
insane	1	2	3	4	5	6	sane
impulsive	1	2	3	4	5	6	rational
selfish	1	2	3	4	5	6	unselfish

After a car mechanic had reported his automobile to be in perfect working order, Thomas P., a 42 year-old male, was driving his car when the brakes gave way. He turned off the road and crashed into a tree. Thomas P. was thrown clear, but his wife burned to death. About a year after her death, on their anniversary, his guilt caused him to kill himself.

Please circle a number from 1 to 6.
Was this suicide:

not justified	1	2	3	4	5	6	justified
cowardly	1	2	3	4	5	6	brave
foolish	1	2	3	4	5	6	wise
unnecessary	1	2	3	4	5	6	necessary
immoral	1	2	3	4	5	6	moral
inappropriate	1	2	3	4	5	6	appropriate
immature	1	2	3	4	5	6	mature
insane	1	2	3	4	5	6	sane
impulsive	1	2	3	4	5	6	rational
selfish	1	2	3	4	5	6	unselfish

Richard S., a 40 year-old man, had been smoking two packs of cigarettes a day for the last 20 years, despite constant warnings from doctors to quit. After a routine physical examination, his doctors informed him that he had cancer. Several months later, he decided to kill himself to avoid the excruciating pain.

Please circle a number from 1 to 6.
Was this suicide:

not justified	1	2	3	4	5	6	justified
cowardly	1	2	3	4	5	6	brave
foolish	1	2	3	4	5	6	wise
unnecessary	1	2	3	4	5	6	necessary
immoral	1	2	3	4	5	6	moral
inappropriate	1	2	3	4	5	6	appropriate
immature	1	2	3	4	5	6	mature
insane	1	2	3	4	5	6	sane
impulsive	1	2	3	4	5	6	rational
selfish	1	2	3	4	5	6	unselfish

After Harold F., a 44 year-old man, gambled the family's savings away, his wife left him, taking the children with her. A year and a half later, he was still struggling with his depression, and after repeated but unsuccessful attempts at reconciliation, he killed himself.

Please circle a number from 1 to 6.
Was this suicide:

not justified	1	2	3	4	5	6	justified
cowardly	1	2	3	4	5	6	brave
foolish	1	2	3	4	5	6	wise
unnecessary	1	2	3	4	5	6	necessary
immoral	1	2	3	4	5	6	moral
inappropriate	1	2	3	4	5	6	appropriate
immature	1	2	3	4	5	6	mature
insane	1	2	3	4	5	6	sane
impulsive	1	2	3	4	5	6	rational
selfish	1	2	3	4	5	6	unselfish

APPENDIX E
FORM B

John B., a 44 year-old male, got drunk and dove off the side of a bridge into very shallow water; he was paralyzed from the waist down. He would be confined to a wheelchair for the rest of his life. John B. killed himself, deciding he could not live that way.

Please circle a number from 1 to 6.
Was this suicide:

not justified	1	2	3	4	5	6	justified
cowardly	1	2	3	4	5	6	brave
foolish	1	2	3	4	5	6	wise
unnecessary	1	2	3	4	5	6	necessary
immoral	1	2	3	4	5	6	moral
inappropriate	1	2	3	4	5	6	appropriate
immature	1	2	3	4	5	6	mature
insane	1	2	3	4	5	6	sane
impulsive	1	2	3	4	5	6	rational
selfish	1	2	3	4	5	6	unselfish

After a car mechanic had reported faulty brakes on his automobile, Thomas P., a 42 year-old male, made no attempt to repair them. While subsequently driving with his wife, the brakes gave way; he turned off the road and crashed into a tree. Thomas P. was thrown clear, but his wife burned to death. About a year after her death, on their anniversary, his guilt caused him to kill himself.

Please circle a number from 1 to 6.
Was this suicide:

not justified	1	2	3	4	5	6	justified
cowardly	1	2	3	4	5	6	brave
foolish	1	2	3	4	5	6	wise
unnecessary	1	2	3	4	5	6	necessary
immoral	1	2	3	4	5	6	moral
inappropriate	1	2	3	4	5	6	appropriate
immature	1	2	3	4	5	6	mature
insane	1	2	3	4	5	6	sane
impulsive	1	2	3	4	5	6	rational
selfish	1	2	3	4	5	6	unselfish

Richard S., a 40 year-old man, was warned by doctors that the form of cancer his father died from might be hereditary. Because of this, he exercised daily and was careful to eat a well-balanced diet. After a routine physical examination, which he received yearly, his doctors informed him that he had cancer. Several months later, he decided to kill himself to avoid the excruciating pain.

Please circle a number from 1 to 6.
Was this suicide:

not justified	1	2	3	4	5	6	justified
cowardly	1	2	3	4	5	6	brave
foolish	1	2	3	4	5	6	wise
unnecessary	1	2	3	4	5	6	necessary
immoral	1	2	3	4	5	6	moral
inappropriate	1	2	3	4	5	6	appropriate
immature	1	2	3	4	5	6	mature
insane	1	2	3	4	5	6	sane
impulsive	1	2	3	4	5	6	rational
selfish	1	2	3	4	5	6	unselfish

After losing a large sum of money when the stock market unexpectedly crashed, the wife of Harold F., a 44 year-old male, left him for another man, taking the children with her. A year and a half later, he was still struggling with his depression, and after repeated attempts at reconciliation, he killed himself.

Please circle a number from 1 to 6.
Was this suicide:

not justified	1	2	3	4	5	6	justified
cowardly	1	2	3	4	5	6	brave
foolish	1	2	3	4	5	6	wise
unnecessary	1	2	3	4	5	6	necessary
immoral	1	2	3	4	5	6	moral
inappropriate	1	2	3	4	5	6	appropriate
immature	1	2	3	4	5	6	mature
insane	1	2	3	4	5	6	sane
impulsive	1	2	3	4	5	6	rational
selfish	1	2	3	4	5	6	unselfish

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BIOGRAPHICAL SKETCH

Michael Steinberg was born March 7, 1961, the second of two children to Harold and Claire Steinberg of Brooklyn, New York. He graduated from Canarsie High School with high honors in 1978. That year he was admitted to the State University of New York at Binghamton, and was awarded the degree of Bachelor of Arts in psychology in 1982.

In August, 1982, Michael enrolled as a full-time student in counseling psychology at the University of Florida. In 1985 he received the degree of Master of Science. In 1987, after an internship at the Veteran's Administration Medical Center in Northport, New York, he will receive the degree of Doctor of Philosophy.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Harry A. Grater, Chairperson
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Franz R. Epting
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Robert C. Ziller
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Mary A. Fukuyama
Assistant Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

James I. Morgan
Associate Professor of Psychology

This dissertation was submitted to the Graduate Faculty of the Department of Psychology in the College of Liberal Arts and Sciences and to the Graduate School and was accepted as partial fulfillment of the requirement for the degree of Doctor of Philosophy.

August, 1987

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Dean, Graduate School